UNITED
NATIONS

CRC

Convention on the
Rights of the Child

Distr.
GENERAL

CRC/C/28/Add.5
17 June 1996

Original: ENGLISH

COMMITTEE ON THE RIGHTS OF THE CHILD

CONSIDERATION OF REPORTS SUBMITTED BY STATES PARTIES
UNDER ARTICLE 44 OF THE CONVENTION

Initial reports of States parties due in 1995

Addendum

FEDERATED STATES OF MICRONESIA

[16 April 1996]

GE.96-17583 (E)

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* The annexes are available for consultation in the files of the secretariat.

List of acronyms

AA	Associate of Arts
ADN	Associate Degree in Nursing
ANC	Ante-Natal Care
APNLC	American Pacific Nursing Leaders Council
ARI	Acute Respiratory Infection
BCG	Bacille Culmette-Guèrin
BSN	Bachelor's of Science in Nursing
CAN	Child Abuse and Neglect
CDC	Centre for Disease Control
CEDAW	Convention on the Elimination of Discrimination Against Women
CME	Continuing Medical Education
COM	College of Micronesia
COM-FSM	College of Micronesia - Federated States of Micronesia
CRC	Convention on the Rights of the Child
CSHCN	Children with Special Health Care Needs
DOT	Directly Observed Therapy
DSM	Diploma in Surgery and Medicine
EENT	Eyes, Ears, Nose and Throat
EPI	Expanded Programme for Immunization
FFPN	Family Food Production and Nutrition
FOB	Free On Board
FSM	Federated States of Micronesia
FSMC	Federated States of Micronesia Code
GDP	Gross Domestic Product
GED	General Educational Development
GED	General Equivalency Diploma
GN	Graduate Nurse
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRH	Human Resources for Health
IDA	Iron Deficiency Anaemia
IEP	Individual Education Plan
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IU	International Units
JABSOM	John A. Burns School of Medicine, University of Hawaii
NACC	National Advisory Council on Children
NEC	Not Elsewhere Calculated
NGO	Non-Governmental Organization
NNPA	National Nutrition Plan of Action
OPS	Office of Planning and Statistics
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PBMOTP	Pacific Basin Medical Officers Training Programme
PHC	Primary Health Care
PHD	*Pacific Health Dialogue*
PIRAPP	Pacific Insular Regional Anti-Substance Abuse Programme
PN	Practical Nurse
PNACC	President's National Advisory Council on Children
SNDP	Second National Development Plan
T3	Trade Training and Testing Programme
TB	Tuberculosis

List of acronyms (continued)

TCP	Teacher Child Parent
TTPI	Trust Territory for the Pacific Islands
UNICEF	United Nations Children's Fund
VAD	Vitamin A Deficiency
VADAV	Vitamin A Deficiency and Vermox
VCR	Video Cassette Recorder
WHO	World Health Organization
WPRO	Western Pacific Region Office
Youth RAP	Youth Referral Alternative Programme

Introduction

1. Children in the Federated States of Micronesia (FSM) today are faced with an ever-changing social, cultural and religious environment. Many of the traditional values and social systems are deteriorating as the nation moves away from a subsistence economy and towards a cash-based economy. The extended family, once the most effective social and community network operating in the Federated States of Micronesia, is now being eroded as the influence of changing social and economic conditions continues.

2. However, it is still true that the nurturing of children into adulthood is a shared responsibility involving all members of the extended family. Most families are willing to make major sacrifices to ensure for their children the best opportunities in life. Families realize today that decisions made on behalf of children will determine the future for the child, family, community and the nation. The traditional social culture placed a strong emphasis on cooperation and responsibility, and with that came a sense of identity and commitment. As this structure is altered, the identity of the children is transformed.

3. Traditional children's roles within the nation vary greatly from state to state. Children's roles within the family vary according to their age, sex, the number of children and the sex of the older and younger siblings. Children start to help out at home as soon as they are physically able. The girls' responsibilities within the family unit primarily revolve around taking care of younger children, cleaning the house and clothes, cooking and making handicrafts. Boys are generally involved in food gathering and production, as well as canoe building and construction.

4. Adulthood is marked in females by the onset of puberty, menstruation or childbearing, and in males either by attaining the age of 18 or their ability to provide for a family (farming abilities, construction skills, etc.).

5. For young women, childbirth was traditionally the culmination of a learning process that began years before. Young women had numerous experiences in caring for children as they helped female relatives with bathing, feeding, clothing and caring for young infants. Today, many young women give birth to babies without these traditionally learned skills. In the past, if young mothers were unmarried, their babies would be cared for by the extended family. Today, this system is clearly not as supportive. There is an increased incidence of child neglect and abuse and suicide in children as a result of this breakdown in the traditional social support system. Skills such as carpentry, canoe building, agriculture, handicraft weaving and fishing techniques, which were traditionally learned through the extended family, are fading from youths' experience.

6. The effects of cultural change may contribute to the developmental difficulties of many adolescents. There appears to be an increased number of youth gangs and juvenile crimes and an increase in school absenteeism rates throughout the nation, although exact figures are difficult to find. The suicide rate among FSM adolescents is excessive.

Population, health and education indicators - 1989

Focus	Indicator	Kosrae	Pohnpei	Chuuk	Yap
Population density	Per square mile	176	250	993	176
Sex ratio	Males per 100 females	102	104	102	105
Fertility	Crude birth rate	36.4	37.3	35.0	38.0
Infant mortality	Rate as of 1989	56.6	56.6	46.3	62
Health services	Number of dispensaries as of 1989	4	11	41	26
Education (public and private)	Total number of schools	7	47	108	32
	Teachers	137	400	1 266	N/A
	Students	2 160	8 968	16 468	2 929
Income	Per capita weekly money income ($)	20.73	16.14	10.25	34.53
	Value of subsistence consumption ($)	11.37	8.4	7.46	14.09
Food	Mean expenditure per person per state ($/week):				
	Local food	2.84	2.07	0.58	0.95
	Imported food	5.25	5.63	5.78	6.40

I. GENERAL MEASURES OF IMPLEMENTATION

A. Measures taken to harmonize national law and policy with provisions of the Convention

1. The law on public health, safety and welfare

7. The law on public health, safety and welfare generally mandates the maintenance and improvement of health and sanitary conditions, minimizing and controlling communicable diseases, establishes standards of medical and dental care and practice, and encourages scientific investigation in the field of health and the supervision of hospitals, clinics, dispensaries and other medical facilities.

(a) Immunization of schoolchildren

8. 41 FSMC §§ 401-409 requires all children to be inoculated for immunization against communicable diseases prior to entering school. No child may be exempted from immunization unless a licensed physician certifies the required immunization(s) would endanger the life or health of the child.

(b) Sanitation

9. 41 FSMC §§ 601-606 provides for laws and empowers authorities to make regulations regarding sanitation. These laws establish criteria for the construction, location and maintenance of toilets and latrines, rubbish and garbage removal and food inspections, and prescribes the minimal acceptable levels of health and sanitation for schools.

(c) Child abuse

10. 41 FSMC §§ 501-506 makes it the policy of the FSM to provide for the protection of children who have injuries inflicted upon them and/or may be threatened or injured by the conduct of those responsible for their care. This law requires every person examining, attending, teaching or treating a child to report suspected abuse.

2. The law on education

11. The Law on Education declares that it is FSM policy to provide an educational system that will enable its citizens to participate fully in the development of the islands, as well as become familiar with the Pacific community and the world. To this end the declared purpose of education is to prepare FSM children for participation in self-government and economic and social government; to preserve Micronesian culture and traditions; to convey essential information concerning health, safety and the protection of the island environment; and to provide its citizens with the social, political, professional and vocational skills to develop the nation.

(a) Compulsory education

12. 40 FSMC § 104 mandates compulsory education for all children, including children with disabilities, from first grade through eighth grade, or until the age of 14. Penalties are provided for parents who knowingly absent their child from school.

(b) Gifted and talented students

13. 41 FSMC § 106 requires the identification and encouragement of children who demonstrate an extraordinary ability to learn. Educational programmes must be designed and implemented to allow children to take advantage of challenging educational programmes and opportunities in Micronesia and abroad.

(c) Children with disabilities

14. 41 FSMC §§ 231-237 provides for free education for children with disabilities to enable them to lead fulfilling and productive lives. This education shall be in regular classes with necessary supplemental and consulting services.

3. The draft national nutrition plan of action 1995-2004

15. At the International Conference on Nutrition in Rome in 1992, the FSM committed itself to developing a national nutrition plan of action. Over the following years, a plan of action has been developed in order to use all available resources in order to formulate concerted actions that will reduce malnutrition and ill-health for the children of Micronesia. The main thrusts of the draft national plan are also consistent with international agreements and commitments, particularly The Children's Summit and the Suva Declaration on Sustainable Human Development in the Pacific.

16. The draft national plan has identified three main objectives for the FSM. First, to ensure continued access by all people to the supply of foods necessary for a diet that is sufficiently safe and adequately nutritious. Specific objectives include decreasing severe protein deficiency in children, reducing the number of stunted children, reducing low birth weight and preventing all clinical signs of vitamin A deficiency in children under five years of age.

17. The second goal is to achieve and maintain the health and nutritional well-being of all children. This includes reducing infant mortality, increasing the use of breast-feeding, ensuring access to safe and potable water and reducing the incidence of both communicable and non-communicable diseases.

18. The third goal is to achieve environmentally sound and socially sustainable development in order to improve nutrition and health. Specific objectives include maintaining the rate of primary school enrolment, increasing the rate of secondary school enrolment and ensuring safe waste-water disposal.

19. The FSM recognizes that firm social, economic and political commitment is needed to ensure that the nutritional well-being of children is seen as an integral consideration of policies, plans and programmes in all sectors both in the short and long term. Agriculture, health, education, central planning and other relevant departments will be encouraged to incorporate nutritional objectives into their programmes. It will be equally necessary to ensure coordination in order to harmonize, promote and monitor programmes of different departments, non-governmental organizations and the private sector. The FSM recognizes that the difficulties involved in doing this cannot be underestimated.

4. The Second National Development Plan 1992-1996

20. The implementation of the Second National Development Plan, which coincided with the FSM accession to the Convention on the Rights of the Child, recognized that this period is a critical one for the nation. The plan sets out the views and aspirations of the national Government and the four constituent states, and provides an integrated overview of the sectoral problems and strategies. In reviewing the problems and issues facing the FSM, a number of themes were identified that provided the basis for the development of more detailed national objectives. These themes have been discussed earlier in this report, with respect to the constraints on basic health and welfare.

B. Strengthening mechanism for coordinating policies relating to children and for monitoring the implementation of the Convention

1. The National Advisory Council on Children

21. On 3 November 1992, the Congress of the Federated States of Micronesia ratified the International Convention on the Rights of the Child (CRC). The instrument of accession was subsequently submitted, on 5 May 1993, to the Centre for Human Rights in Geneva. It was necessary for the Government either to designate a department or create a council whose responsibility would be to coordinate and monitor implementation of the Convention. Since the Convention encompasses many areas of concern for the child, a council was organized. In addition to oversight of implementation of the Convention, this Council was also charged with responsibility for preparing the report to be submitted to the Committee on the Rights of the Child two years after accession.

22. In line with this accession, the FSM also agreed to make certain provisions for children. The draft situation analysis of FSM children had identified the status of children's health, education and existing services and resources for FSM children. The draft national plan of action for children takes the process a step further by identifying specific goals, objectives and responsibilities needed to achieve the global goals and to provide better service delivery to the children of FSM.

23. Responding, with a sense of urgency, to the requirement for monitoring activity, the Secretary of the National Department of Health Services took the

step of creating a council whose members represented both the FSM national Government and non-governmental organizations in Pohnpei, the capital of the FSM. Membership in the Council included the Office of the Attorney General, the Department of External Affairs, the Division of Labour, the Office of Planning and Statistics, the Department of Education, the Department of Health, the Office of Immigration, the Department of Resources and Development, the Women's Interests Programme, and the Pacific Basin Medical Officers Training Programme, physically located in Pohnpei, and the United States Peace Corps Volunteer Headquarters, also located in Pohnpei. The first meeting of the Council was held on 11 November 1994, and on 4 January 1995, the officers were formally selected.

24. In collaboration with the Attorney General's Office, the National and State-level Advisory Council for Children shall take on the responsibility for implementing, monitoring and reporting on the Convention. The priority task for the Council in implementing the Convention is to create public understanding about its content, as well as to ensure that relevant departments and organizations are informed of their roles and responsibilities in implementing it.

25. As the Council proceeded with the preparation of the FSM report on the Convention and as it addressed critical issues regarding the well-being of FSM children, it was felt that the status of the Council needed to be raised. On 9 October 1995, the Secretary of the Department of Health Services, through the Office of the Attorney General, requested the President, His Excellency Bailey Olter, to make it a presidentially appointed council. On 6 November 1995, President Olter appointed the Council as the President's National Advisory Council on Children (PNACC). This promotion was necessary so that both national and state agencies, as well as the general public, will fully recognize and appreciate the importance that the President's Office and the FSM Government attach to the essential work of the Council.

2. Measures taken to make the principles and provisions of the Convention on the Rights of the Child known to the public

26. Upon the accession of the FSM to the Convention on the Rights of the Child, President Bailey Olter issued a proclamation regarding the Convention which was distributed to each state governor, as well as all government and non-governmental agencies.

27. Educational literature has been widely distributed at workshops, seminars and conferences for further distribution to parents and children. The publications include Questions and Answers Most Parents Ask, First Call for Pacific Children and a translation of the Convention into non-technical English. In addition, the video "First call for pacific children" has been shown to a variety of parent groups.

28. In September 1994, the FSM-based Pacific Basin Medical Officers Training Programme and the Fiji School of Medicine published "Focus: Pacific child health" in Pacific Health Dialogue - a new journal of community health and clinical medicine for the Pacific. The lead article was "Convention on the

Rights of the Child: Implications for health and well-being of Pacific children". This issue of the PHD, funded by UNICEF and addressing children's issues in the Pacific, was widely disseminated to FSM health professionals. Follow-up articles regarding the implementation of the Convention throughout the Pacific (and in the FSM) are planned for future PHD issues.

29. Conferences, seminars and workshops on child-related issues have been organized, principally by the Departments of Health Services and Education. They include the 1993 National Youth Conference in Kosrae, the 1994 Pacific Insular Regional Anti-Substance Abuse Programme (PIRAPP) workshop in Pohnpei, Child Abuse and Neglect Workshops in 1991, 1992 and 1993, the second Annual Family Food Production and Nutrition (FFPN) Workshop in 1995, the National Teacher Child Parent (TCP) Workshop, the National Women's Conference in Chuuk, the Nutritional Health Workshop in Yap and the 1995 Pacific Region Educational Laboratory held in the Republic of Palau.

30. Despite dissemination of the principles contained in the Convention, much work, primarily at the grassroots level, needs to be done. Many parents are still unaware of the Convention, and more importantly, of the benefits to their children of implementing its principles. Many parents need to be educated and encouraged to adopt a more responsible approach to the protection, care and education of children.

3. International coordination/cooperation

31. Respect for the fundamental human rights of the individual is deeply rooted in the traditional history of the people of the FSM. As a nation of many small islands, subsistence communities dependent on the skills of their members, respect for fundamental human rights is crucial to the very survival of its people.

32. When the nation emerged as a sovereign State, it enshrined the principles of respect for the fundamental human rights of individuals as an important article of its national Constitution. With this foundation, when the FSM became a member of the world community by joining the United Nations in September 1991, it continued to participate actively in international efforts to protect and promote fundamental human rights in the world community.

33. The FSM participated actively in the Preparatory Meeting of the World Conference on Human Rights and contributed to the work of the Conference when it was convened in Vienna in June 1993.

34. The FSM acceded to the Convention on the Rights of the Child on 5 May 1993, the first international human rights instrument to which it acceded as a new nation. By this accession, the FSM has given its formal recognition and commitment to fundamental principles long practised in its traditional history.

35. As part of the former Trust Territory of the Pacific Islands, the administering authority (the United States) acceded on behalf of the people to certain human rights instruments. When the FSM joined the United Nations it

pledged to abide by their principles and provisions while the new Government reviewed such instruments/treaties with a view to the possible accession of the FSM to them as an independent new State. These instruments include:

(a) Inter-American Convention on the Granting of Political Rights to Women (signed in Bogota, 2 May 1948);

(b) Convention on the Political Rights of Women (done at New York, 31 March 1953);

(c) Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery (done at Geneva, 7 September 1956) (with reservation);

(d) Protocol relating to the Status of Refugees (done at New York, 31 January 1967) (with reservations).

36. Additionally, at the Vienna Conference on Human Rights in 1993, the Government of the FSM expressed its commitment to reviewing, with a view to acceding to them, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights.

37. The FSM has also completed its legal review of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and has submitted the Convention to the National Congress for ratification.

38. The FSM, through its Permanent Mission to the United Nations, has participated in the human rights field at the United Nations in the context of the Third Committee. This Committee deals with social and humanitarian issues. Since becoming a member of the United Nations, the FSM has actively participated in the work of this Committee and joined other nations to reach consensus on a broad range of human rights issues: women's rights, rights of migrant workers and their families, rights of indigenous people, children's rights and related matters.

39. The FSM was a joint sponsor of a General Assembly resolution seeking to eliminate capital punishment, addressing the plight of street children, and of several resolutions on women's rights.

40. Other conferences in which the FSM participated which addressed the issue of human rights included the International Conference on Population and Development, the World Summit for Social Development, the thirty-ninth session of the Commission on the Status of Women and the Fourth World Conference on Women.

41. Regionally, the FSM Secretary of Health Services was a signatory of the Yanuca Island Declaration in Fiji (10 March 1995) at the World Health Organization-sponsored Ministerial Conference on Health for the Pacific Islands. There, the FSM supported Pacific Island-wide efforts to promote health and protect the environment through the appropriate development of human resources for health and integrated planning.

II. DEFINITION OF THE CHILD

Article 1

1. Legal context

42. Article 1 of the Convention considers a child to be a person under the age of 18 years. In the FSM, the age of majority often depends on the activity the child might be engaged in.

(a) Suffrage rights

43. The National Constitution grants the right to vote in national elections to all citizens 18 years or older. Each state constitution grants the same rights of suffrage. All citizens 30 years old or more are eligible to be elected to Congress.

(b) Juvenile offenders

44. 12 FSMC § 1101 mandates that in all criminal cases involving child offenders under the age of 18, the courts shall adopt a flexible procedure for resolving such cases. An offender 16 years or older may, however, be treated in all respects as an adult if the physical and mental maturity so justifies. If detention is necessary, children are kept apart from adult offenders.

45. Any child under the age of 18 who is adjudicated a delinquent child, i.e., one who violates national law, shall not be considered to have a criminal conviction. Pursuant to the FSM Constitution, no one may be compelled to give evidence in a criminal case.

(c) Domestic relations

46. 6 FSMC § 1616, Domestic relations, states that all persons who have attained the age of 18 shall be regarded as of legal age and their period of minority to have ceased.

47. The minimum age of marriage is controlled by the individual states and generally requires the male to be 18 years of age and the female 16 years of age. If the female is less than 16 years old she must obtain the permission of one parent. Customary marriage is recognized.

48. The age of sexual consent varies from state to state. In Yap the age is 13; in Pohnpei the age is 15; in Chuuk the age is 13; and in Kosrae the age is 13.

(d) Children in the military

49. FSM has no military, although its citizens are allowed to enlist in the United States military. United States laws and policies on enlistment govern these matters.

(e) Citizenship

50. 7 FSMC § 101, Citizenship, grants citizenship to any child born to FSM citizens residing outside the country until the age of 21; however, such child must become a permanent resident of FSM by the age of 21.

51. Persons 18 years or older may become naturalized citizens of the FSM, if it is proved they are a child of a FSM citizen. No FSM citizen can lose their citizenship unless there is a voluntary renunciation of that citizenship.

(f) Education

52. 40 FSMC § 104, Education, requires school attendance of all children between the ages of 6 and 14, or until graduation from elementary school by the eighth grade. It is a criminal offence for parents to permit their child's absence from school. All elementary education is provided free of charge.

53. In 1994, the FSM Congress passed a law providing for special education services for children with disabilities, from birth to the age of 21.

(g) Child labour

54. Currently, there are no national laws relating to child labour. Although child labour exists in the FSM, it is not labour of an exploitative kind. Fishing and some agriculture, common to the subsistence nature of the FSM economy are examples of tasks children might do on behalf of the family. The Division of Labour is currently reviewing existing legislation to determine the need for child labour safeguards, such as minimum hours, wages and working conditions.

(h) Substance abuse

55. There are no national laws regarding the age when one may legally use alcohol or drugs; such laws are left to the individual states and municipalities. Generally, the age by which one may consume alcohol is 21. All drugs (controlled substances) are prohibited regardless of age.

III. GENERAL PRINCIPLES

Article 2. Non-discrimination

1. Legal context

56. This principle is embodied in the FSM Constitution, article IV, section 4, which states, "Equal protection of the laws may not be denied or impaired on account of sex, race, ancestry, national origin, language or social status."

(a) Bill of Rights

57. 1 FSMC § 107, Bill of Rights, adds that, "No law shall be enacted ... which discriminates against any person on account of race, sex, language or religion".

58. These constitutional provisions are the touchstone for all laws promulgated in the FSM. In a country comprised of island states, each with unique customs, traditions and languages, and in a country where sharing and communal work are part of the culture, there is inherent an equal treatment of all people.

2. Implementation

(a) Education

59. In 1993, the FSM Congress allocated an additional two million dollars for renovations and additions to existing high schools. Although this will not eliminate the shortage of high school space, it will alleviate some of the problems.

60. Also, in 1994, the FSM Congress provided for special education services for children with disabilities (40 FSMC § 231). The law specifically acknowledges FSM's responsibility to provide free educational opportunities to all children including the disabled, which will enable them to lead fulfilling and productive lives.

(b) Women's interests

61. In 1992, the post of Women's Interests Officer was created in the national Government, and the National Women's Advisory Council was formed. This is the first step towards further incorporation of women in the development process and recognizing women's contribution to the future well-being of the nation, although much needs to be done before the role and public perception of women is restored to its previous position of prestige and respect.

3. Constraints

(a) Education

62. Although there is no de facto discrimination, because insufficient educational resources require many children to end school at the eighth grade, generally only those families with sufficient income can afford to send their children to higher levels of education. High schools throughout the FSM are not equipped to place all of the elementary school graduates. Until 1994, 40 to 50 per cent of elementary school students did not pass the required high school entrance examinations. In 1994, these examinations were abolished and all students may now attend high school. Insufficient educational resources,

however, means that many students still lack the proper educational tools. For youths who do not have the opportunity to continue their education, there are limited opportunities to enter the job market.

(b) Women's interests

63. With the exception of the main island of Yap, the societies in the FSM are matrilineally ordered. Therefore, women in the FSM command significant respect. Traditionally, women were assigned to reproductive and domestic responsibilities. Although these were designated specifically as women's responsibilities, they were complementary to those of the men. These complementary gender roles dictated mutual power sharing between men and women, informally and in community relationships. Paradoxically, colonization and imported value systems have undermined this prestigious position of women and instead initiated the disempowerment and marginalization of women in contemporary FSM society.

Article 3. The best interest of the child

1. Legal context

(a) Bill of Rights/education

64. The FSM Bill of Rights and 40 FSMC, Education, guarantee free elementary education to all children in the FSM.

(b) Social security

65. 53 FSMC, Social Security, provides for children who are dependent on parents/guardians over the age of 60, or who were dependent upon deceased person(s) covered by the system. Such children receive support until they reach the age of 18, marry or are adopted by a non-relative.

(c) Domestic relations

66. 6 FSMC, Domestic Relations, requires the court, in matters of divorce and child custody, to make orders for the custody and support of the children as it deems just and in the best interests of all concerned.

(d) Adoption

67. 6 FSMC, subchapter III, Adoption, disallows any adoption without the child appearing before the court; the adoption shall only be granted if the court is satisfied that the best interests of the child will be promoted. No child 12 years or older may be adopted without the child's consent.

(e) Health, safety and welfare

68. 41 FSMC, Health, Safety and Welfare, paragraph 40 mandates that no child shall attend school, unless they have been immunized against identified communicable diseases.

(f) Health insurance

69. 52 FSMC, National Government Employees Health Insurance, provides health insurance to all dependent children of eligible members. Dependent children must be 22 years of age or younger. Currently, almost 11,000 children are covered by the health insurance plan.

(g) Child abuse

70. 41 FSMC, Child Abuse, makes it a policy of the FSM Government to provide protection for all children who have injuries inflicted upon them and who may be threatened or injured by the conduct of those responsible for their care and protection. A child means any person under the age of 18.

(h) Juveniles

71. FSMC, chapter 11, Juveniles, requires the court to consider the best interests of the child when determining the appropriateness of confinement following an adjudication of delinquency.

2. Implementation

72. In the past two years, many, although by no means all, of the issues affecting the best interests of the child have been addressed.

73. Exemption from required child immunizations on the basis of religious or personal beliefs has been eliminated from the law. Congress specifically made reference to the Convention on the Rights of the Child and to the need for personal belief to give way to a compelling social purpose.

74. A FSM draft nutritional plan of action was developed in response to nine recommendations of the 1992 International Conference on Nutrition. These objectives include reducing the numbers of low birth weight infants and vitamin A deficiency in children. The objectives also include maintaining the numbers of children in the elementary school system, while increasing enrolment in post-elementary education.

75. Health insurance eligibility has been broadened to include all employees of state governments and private businesses and their dependents.

76. New national child abuse legislation has been proposed that would link the provision of funding to the states with the establishment of reporting requirements, broadening the definition of child abuse and setting minimum standards to be followed in the reporting and investigation of child abuse incidents.

3. Constraints

77. The constraints regarding the best interest of the child in the FSM are mainly due to the accelerated rate of social, economic, educational and environmental change occurring as the nation develops.

78. As discussed earlier, there are generally inadequate economic resources to provide post-elementary education. The insufficient educational opportunities appear to have a negative domino effect, which leads to poor employment prospects. Lack of jobs, combined with few recreational and social activities, appears to correlate with increased teenage pregnancies and epidemic proportions of alcohol consumption among youths.

79. Child abuse and neglect are a growing problem in the FSM. Disrupted cultural safeguards and taboos are relevant factors in this increase. Underreporting of abuse incidents is believed to be significant and is related to cultural sensitivity concerning these issues.

80. The FSM also experiences significant nutritional problems among its children. These problems, however, appear to be due more to the consumption of nutritionally unhealthy food or inappropriate food than to inadequate nutritious food supplies.

Article 6. The right to life, survival and development

1. The legal context

81. Although these rights are guaranteed and/or implied by statutes and programmes mentioned above, additional reference is made to the following.

(a) Equal protection

82. The FSM Constitution, article XIII, paragraph 1, recognizes the rights of citizens to education, health care and legal services. Article IV, paragraph 3, states that no person may be deprived of life, liberty or property without due process of law, or be denied the equal protection of the law. Article IV, paragraph 9 prohibits capital punishment.

(b) Child support

83. 6 FSMC § 1622 requires the court, in cases of divorce, to order support to be paid for the child's care. This order of support can be changed at any time to reflect the changed financial circumstances of the parents.

(c) Education

84. Education, including special education for children with disabilities, is recognized as a right, with the goal being to have all children live productive and fulfilling lives (40 FSMC, para. 232).

2. Constraints

85. In addition to the constraints addressed earlier, the major obstacle regarding article 6 is malnutrition and ill-health among FSM children, which is potentiated by the maldistribution of health-care funds, which are largely spent on hospital-based curative care in central locations and off-island medical referrals for a few. Because of these inequitable expenditures, the development of primary health care (PHC) has been underfunded. Hence, most FSM citizens, who live in rural areas and remote atolls (over 50 per cent of

whom are women and children), do not have ready access to the most basic PHC services. This group is over-represented in terms of death and suffering from common diseases which, for the most part, are treatable and/or preventable through low-cost technologies and low-cost medications.

3. Solutions

86. There is a need to develop an organized and reliable PHC system to which all FSM residents have ready access.

Article 12. Respect for the views of the child

1. Legal context

(a) Freedom of expression

87. The FSM Constitution, article IV, paragraph 1, states that no law may deny or impair freedom of expression, peaceable assembly, association or petition.

(b) Adoption

88. 6 FSMC § 1633 forbids the adoption of any child over the age of 12 years without the child's consent.

2. Implementation

89. Progress needs to be made in this area. Currently, National Youth Offices, under the FSM Department of Education, as well as community-based organizations like scouting and church groups, are providing a conduit through which children's concerns can be raised and respected.

3. Constraints

90. The fundamental law of the FSM protects anyone's, including a child's, right to present their views. Respecting these views is not the same, however, as allowing their expression. Children in the FSM do not have many vehicles by which to express their views to an attentive audience. In part, this is because, culturally, children's views are neither encouraged nor desired in many Micronesian households. Parents will need to be educated as to the need for, and benefits of, child expression.

IV. CIVIL RIGHTS AND FREEDOMS

Article 7. Name and nationality

1. Legal context

(a) Citizenship

91. The FSM Constitution, article III, Citizenship, states that a person born of parents, one or both of whom are citizens of the FSM is a citizen and national of the FSM by birth. This right is reiterated in 7 FSMC § 202 (2).

(b) Adoption

92. 6 FSMC § 1635 states that after a decree of adoption the child adopted and the adopting parent or parents shall hold towards each other the legal relation of parent and child and have all the rights and be subject to all the duties of that relationship.

2. Implementation

93. The rate of registration of the newborns and subsequent issuance of birth certificates and official designation of nationality is 80 per cent. Hospital nurses, midwives and health assistants are designated as reporting agents for births and must transmit their reports to the State Director of Health Services. Two copies of the birth certificate are prepared; the original is sent to the office of the Clerk of the Court for filing and indexing as a legal document.

3. Constraints

94. The 1994 FSM National Census estimates that births are 20 per cent under-reported. The system of registration is good, but persons responsible for registration and record-keeping often assign a low priority to these tasks. Under-reporting may also be attributed to lack of a strong coordinated reporting policy at the national, state and community levels.

4. Solutions

95. Education is needed to stress and encourage the importance of accurate birth registration. Mothers should not be discharged from hospitals prior to completing certificate information. Public health teams that visit at home births need to bring certificates to be completed. Birth reporting must be assigned a higher priority and a clear policy should be established at the municipal and hospital levels regarding procedures on birth registration. A civil registration system has been discussed at the national and state levels to require information on matters of birth, marriage and divorce.

Article 8. Preservation of identity

1. Legal context

96. The FSM recognizes and protects a child's identity by way of nationality, name and family relations. The preservation of identity is through no specific law, but rather an amalgamation of laws including those on citizenship, marriage/divorce and social security.

2. Implementation

97. The established system works well in preserving this right. There have been no reported cases of persons losing their national or family identity and/or state interference with such identity.

Article 13. Freedom of expression

98. The freedom for children to speak their minds has already been discussed under the heading of respect for the views of the child. Freedom of speech is one of the core rights contained in the Bill of Rights and is recognized as fundamental in developing an open, free and educated society. Educating citizens as to the importance and benefits of using this valuable right is necessary before the full benefits will be realized.

Article 17. Access to appropriate information

1. Legal context

(a) Freedom of expression

99. The FSM Constitution, article IV, section 1, prohibits laws denying or impairing freedom of expression.

(b) Freedom of speech

100. 1 FSMC § 101, Bill of Rights, prohibits laws abridging freedom of speech, as of the press.

2. Implementation

101. Children in the FSM receive and have access to information from a number of sources. More and more families are buying televisions, video recorders, news magazines and books. Public libraries in each state devote much of their resources to children's literature. Each state has a radio station which devotes programming time to children's shows. Schools and hospitals are making use of radio stations, posters, videos and skits to provide children access to information. State youth offices play a lead role in operating summer work programmes and providing general education on subjects such as family planning, HIV/AIDS and parenting skills.

3. Constraints

102. One of the major problems in providing information that will benefit children socially and culturally is the absence of a strong local media. This problem is exacerbated by the geographical configuration of the FSM. While there is a local newspaper, it is published only on a monthly basis and is directed to adults. The only other newspaper available on a semi-regular basis is United States based (Guam) and provides little information specifically relevant to FSM children. Ironically, with the increased viewership of United States-based television programming, a common complaint is increasing access to inappropriate information. Parental guidance and education will be needed to use media such as television and video to maximum positive benefit.

Article 14. Freedom of thought, belief and religion

1. Legal context

(a) Freedom of religion

103. The FSM Constitution, article IV, section 2, prohibits any law respecting an establishment of religion or impairing the free exercise of religion.

2. Implementation

104. All the traditional religions of the FSM ceased to exist at the turn of the century, in part as a result of missionary influence. Today the FSM population is predominantly Christian, divided between Roman Catholic and Protestant. Faiths include the Assembly of God, the Jehovah Witnesses, the Seventh-Day Adventists, the Church of Jesus Christ of Latter-Day Saints and the Baha'i faith. Children usually adopt the faith of their parents, but are free to choose any faith. The State does not interfere with religious choice, although the church plays an important role in FSM society and government funds may be provided to parochial schools for non-religious purposes.

105. In addition, school activities and government-sponsored contests ensure and encourage the expression by children of their views. FSM National Law Day is celebrated every 12 July, when children participate in a nationwide debating competition addressing controversial and topical issues affecting the country.

Article 15. Freedom of association and peaceful assembly

1. Legal context

(a) Constitution

106. The FSM Constitution, article IV, section 1, prohibits any law impairing the freedom of peaceable assembly or association.

(b) Bill of Rights

107. 1 FSMC § 101, Bill of Rights, prohibits any law prohibiting or abridging the right of peaceable assembly.

2. Implementation

108. The major emphasis in children's associations and programmes is in developing sports facilities and organizing youth league sports. In July 1995, the first FSM Olympic Games was held with over 400 participants from the four states.

109. Several community-based organizations have been developed to provide other structured activities for the large youth population. Scouting organizations, church groups and 4-H programmes provide opportunities for children to come together and learn a variety of skills.

3. Constraints

110. With declining finances and an increasing youth population, it is unlikely that the Government will be able to provide the level of services needed to support youth organizations. And while non-government organizations play an important part in complementing government services, the demand far exceeds the supply of such services. This is a situation which is likely to continue unless a major investment of resources is diverted to youth activities.

Article 6. Protection of privacy

1. Legal context

(a) Constitution

111. The FSM Constitution, article IV, paragraph 5, guarantees the right for persons to be secure in their persons, houses, papers and other possessions against unreasonable searches, seizures or invasions of privacy. These rights are reaffirmed in 1 FSMC § 103, the Bill of Rights.

(b) Juvenile offenders

112. 12 FSMC § 1101 (1) (c) provides that courts shall use flexible procedures in cases involving juvenile offenders. This includes closed courtrooms, the sealing of records and, if detention is necessary, separation from adult offenders.

2. Implementation

113. The child's right to be protected from interference in family life, to privacy and from statements that may harm the honour and reputation of the child is gaining recognition in the FSM. Practices protecting these rights are better recognized and applied in the legal context than family life. Paradoxically, the deterioration of the extended family has increased familial awareness of individual privacy rights.

3. Constraints

114. The traditional social culture places a strong emphasis on cooperation, community and responsibility. The extended family and tight-knit communal-type living is contrary to a recognition of a child's privacy within the family unit. As these traditional values and social systems deteriorate, the sense of individual identity is being altered and the understanding of, and the need for, privacy is enhanced.

Article 37 (a). The right not to be subjected to torture or other cruel, inhuman and degrading treatment or punishment

1. Legal context

(a) Cruel and unusual punishments

115. The FSM Constitution, article IV, section 8, prohibits the infliction of cruel and unusual punishments.

(b) Capital punishment

116. The FSM Constitution, article IV, section 9, prohibits capital punishment.

(c) Juvenile offenders

117. 12 FSMC § 1105 requires the court to consider the best interests of the child when determining if any period of detention must be served following the conviction of a juvenile for a criminal offence.

2. Implementation

118. There is no information available that would support the conclusion that any FSM children are being subjected to cruel and/or inhuman treatment or punishment by the national or state governments. Currently, no children are being detained as a result of criminal offences.

V. FAMILY ENVIRONMENT AND ALTERNATIVE CARE

Article 18, paragraphs 1 and 2, Parental responsibilities; and Article 27, Recovery of expenses associated with child care in cases of divorce

1. Legal context

(a) Juveniles

119. 12 FSMC § 1107, Juveniles, states that a parent or guardian having custody of a child is charged with the control of such child. This law allows parents to be fined for not exercising reasonable parental control and authority over their children.

(b) Truancy

120. 40 FSMC § 104 holds parents liable who knowingly permit a child under their control to be absent from school, or who knowingly prevents any child from attending school.

(c) Child support

121. 6 FSMC, chapter 17 provides for obtaining monetary support from non-custodial parents for their children.

2. Constraints

122. Generally, parents in the FSM accept responsibility for the care of their children. The nurturing of children into adulthood is a shared responsibility involving all members of the extended family. These traditional values and social systems are deteriorating as the FSM moves away from a subsistence economy to a cash-based economy. The FSM has not yet addressed the question of how children may be affected by the potential breakdown in the traditional support system.

123. The other anticipated constraint regards the population growth rate in the FSM. The overall population is increasing at a rate of approximately 3 per cent, which means that by the year 2000 the population will have increased by more than 40 per cent. Population projections indicate that in the next 10 years there will be more than 4,400 children under 5 years of age - an increase of 20 per cent. Those children already born (in the 0-4 age group today) will increase the number of children seeking school placement by 2,000 - an increase of 23 per cent. And there will be 4,800 more children in the age group 15-19 looking for jobs or advanced education.

124. These increases, and the strains they will put on already limited resources, pose a danger to parents' continued ability to provide for the protection, care and education of their children. Work has recently begun in the FSM to develop a population policy that will address concerns raised by the expanding population.

Article 9. Separation from parents

1. Legal context

(a) Child abuse

125. 40 FSMC § 501, Child Abuse makes it a policy to remove and protect children from circumstances and conditions which have caused them injury. Aside from this situation, there is no law allowing removal of children from their families.

(b) Parental responsibilities

126. 6 FSMC § 1622 provides that parents have rights and responsibilities for their children following divorce. Granting custody of a child to one parent does not absolve the non-custodial parent from responsibilities - financial or otherwise - regarding the child.

2. Implementation

127. The Child Abuse and Neglect/Sexual Abuse Programme is community-based, culturally sensitive and family centred. The main goal of the programme is to "protect children from harm and bring families together". It is a prevention programme and the approach used is, prevention through education.

128. Counselling is undertaken educationally rather than clinically. Since the implementation of the programme in 1991, no child has been removed from

his or her home owing to physical abuse, neglect or sexual abuse. All cases have been taken care of within the home, to prevent abuse and neglect and to harmonize families.

Article 10. Family reunification

1. Legal context

(a) Migration

129. The FSM Constitution, article IV, paragraph 12, recognizes a citizen's right to travel and migrate within the FSM.

(b) Passports

130. 50 FSMC § 202 authorizes issuance of passports to FSM citizens.

2. Implementation

131. Migration within and immigration from the FSM is not restricted or construed in any manner which prohibits or inhibits families and children from remaining in contact. Many persons, particularly young people, leave the FSM seeking employment/educational opportunities abroad.

Article 20. Children deprived of a family environment

1. Legal context

(a) Child abuse

132. 41 FSMC, chapter 5, Child Abuse, places the responsibility on the FSM Government for the care and protection of children removed from their homes because of abuse.

(b) Juveniles

133. 12 FSMC, chapter 11, Juveniles, requires that children adjudicated as delinquent be confined in a place and under conditions the court deems are in the best interests of the child.

2. Implementation

134. There are no recent statistics in the FSM regarding divorce and separation and/or their impact on children. Unofficial results from the 1994 FSM National Census indicate that approximately 3.4 per cent of the population has been divorced or separated. Anecdotal information would indicate that divorce is on the increase.

135. Traditionally, the extended family has ameliorated concerns regarding single-parenting and non-custodial parenting responsibilities. With the erosion of the concept of the extended family and the rise of a cash-based economy, however, the failure of non-custodial parents to accept responsibility for their children is increasing.

Article 21. Adoption

1. Legal context

(a) Adoption

136. 6 FSMC § 1634 states clearly that no adoption shall take place without the child appearing before the court and the court being satisfied that adoption is in the best interests of the child. § 1633 requires the consent of any child over the age of 12 before adoption.

2. Constraints

137. The national law also recognizes that a child may be adopted according to local custom. In such circumstances, the court has no authority in the adoption. A local adoption usually requires nothing more than parents willing to give up their child and parents willing to accept the child. Consequently, there are no safeguards that such adoption is in the best interests of the child.

Article 11. Illicit transfer and non-return of children

1. Legal context

(a) Kidnapping

138. 11 FSMC § 918 designates "kidnapping" as a crime. Kidnapping includes removing any child under the age of 14 without the consent of the child's parent or guardian.

2. Implementation

139. There are no reported cases of FSM children having been kidnapped either within or outside of the FSM. Neither the social nor economic conditions of the FSM are of the type that would create circumstances likely to encourage kidnapping. Additionally, the geographic location of the country, as well as its ocean boundaries, would make kidnapping difficult.

Article 19. Abuse and neglect of children; Article 39. Rehabilitation of abused children

1. Legal context

(a) Child abuse

140. 41 FSMC, chapter 5, Child Abuse, requires the reporting of cases of child abuse and protection of children who are victims of abuse.

(b) Criminal Code

141. 11 FSMC, Criminal Code, provides numerous crimes that constitute abuse and related punishments.

2. Implementation

142. The Child Abuse and Neglect Programme (CAN) was set up in 1991, with funding from the United States of America. However, this funding terminated in October 1993, and the FSM Congress took over full responsibility for funding CAN as of October 1994. This makes the FSM the first of the former United States jurisdictions to support its own CAN programme, which has also been strengthened through the signing of the Convention on the Rights of the Child, which has increased awareness of such issues.

143. Care has been taken to develop culturally sensitive delivery of services, specific to each state, in order for each state programme to keep pace with the different rates of sociocultural development. As in Western countries, child abuse and neglect is considered a very sensitive issue; the programme therefore has to move slowly to gain social acceptance before being able to intervene more actively in many cases. To date, Kosrae is the only state to have passed a child abuse and neglect law.

144. Although data are now being collected on the incidence of child abuse and neglect, there is almost certainly significant under-reporting. Numbers of cases reported probably have more to do with cultural values and restraints than actual distribution or incidence of the problems (more cases which are of a less culturally sensitive nature are reported). At present, it appears that many of the interventions are for educational and medical neglect (i.e., children being kept away from school or infants that have not been taken to medical facilities), rather than physical neglect or abuse (including sexual). Yap is the only state to have used the Public Safety Department in child abuse and neglect cases. This is, in part, due to the mechanism set up for the screening and handling of CAN cases in Yap.

3. Constraints

145. The constraints regarding the protection of children from abuse and neglect generally fall into two broad categories - cultural and legislative.

146. Culturally, many people have yet to be educated and understand what types of behaviour may constitute abuse and the deleterious effects that behaviour has on children. In addition, people are often inhibited in reporting abuse because of the perceived shame it may cause both perpetrator and victim. Paradoxically, while the breakdown in the traditional social support system is believed to be leading to an increased incidence of child abuse, the confidentiality that was also a part of that support system has not eroded.

147. The legislative constraints are largely due to inadequate funding and support. There is a lack of adequately trained personnel in some states and there is insufficient funding to send persons to train individuals. Part of the legislative malaise is the result of inadequate information to convince lawmakers of the growing problem.

VI. BASIC HEALTH AND WELFARE

Article 6, paragraph 2. Survival and development

148. The FSM Constitution and the Law on Public Health, Safety and Welfare promote and protect the basic well-being of all residents of the FSM, including the most vulnerable members of the community - mothers and children. As a newly independent developing country, which covers a Pacific expanse of one million square miles, providing and consistently maintaining adequate health care and environmental health services and education for FSM families is a mission which tests the resources, organization and resolve of the new Government. Additionally, with socio-economic development and the departure from subsistent family-based economies, the rapidly growing communities of the FSM are also experiencing Pacific-wide changes in health and disease, reflected in the phenomenon of transition morbidity and mortality - the departure from communicable disease as the leading cause of death and suffering to the ascendancy of what are called the "new" mortality and morbidities associated with unhealthy behaviour and lifestyles. Potentiating the impact of both the new (lifestyle) and more traditional (communicable disease) morbidities are rapid population growth, urbanization of capital islands and environmental degradation.

149. Underscoring its resolve to address these difficult issues, the FSM in March 1995, was one of the 17 Pacific island countries that signed the Yanuca Island Declaration at the WHO-sponsored Ministerial Conference on Health for the Pacific Islands, held in Fiji. In that Declaration, the FSM reaffirmed its resolve - along with the rest of the Pacific island nations - to address many of the above-mentioned challenges, emphasizing the need to promote health, protect the Pacific island environments, train and manage human resources for health and integrate this process with planning, all of which are practical strategies to promote the well-being of FSM children and adults to the end of this century and into the next millennium. The principles of the Yanuca Island Declaration are consistent with the goals of the FSM draft National Plan of Action for Nutrition - 1995-2004.

1. Legal context

(a) Immunization

150. 41 FSMC § 403 requires all children to be immunized against communicable diseases prior to entering school.

(b) Sanitation

151. 41 FSMC, chapter 7, Sanitation, sets standards and practices for the construction of toilets, sanitary conditions of property, removal of rubbish and inspection of food and schools for acceptable standards of health and sanitation.

(c) Education

152. 40 FSMC, chapter 1, Education, provides for free, compulsory education for all children between the ages of 6 and 14 or until the completion of the eighth grade.

(d) National plan of action

153. The draft national plan of action for nutrition was developed following the 1992 International Conference on Nutrition in Rome. Three main objectives have been identified:

(i) To ensure continued access by all people to the supply of foods necessary for a diet that is sufficiently safe and adequately nutritious;

(ii) To achieve and maintain the health and nutritional well-being of all the people;

(iii) To achieve environmentally sound and socially sustainable development to improve nutrition and health.

2. Health status of FSM children

154. The standard of children's health in the FSM, as measured by mortality and illness patterns (morbidity), is consistent with that of a developing nation. The infant mortality rate (IMR) of 50/1,000 live births is comparable to those of Kenya, Papua New Guinea and Brazil. The infant mortality rate (the number of infants under 12 months old who die per 1,000 live births) is an indicator used to reveal the overall health of a nation. In the FSM it is unnecessarily high. Various estimates range from 17 (reported) to 52 (estimated on unreported deaths and census data) per 1,000 live births. It is believed that many infant deaths go unrecorded. Almost one third of all reported deaths in under fives, between 1986 and 1992, were due to perinatal complications. Just three conditions are the cause of most childhood deaths: respiratory infections, malnutrition and perinatal conditions. In 1994, the five leading causes of infant (0-12 month old) mortality were: conditions originating in the perinatal period (40 per cent), respiratory disease (17 per cent), intestinal infectious and parasitic diseases (9 per cent), digestive system diseases including malnutrition (5 per cent), diarrhoeal diseases (5 per cent) and meningitis (5 per cent). For the under-five population, leading causes of death are: perinatal conditions (26 per cent), malnutrition (17 per cent), respiratory disease (17 per cent), diarrhoeal diseases (8 per cent) and intestinal infectious and parasitic diseases (8 per cent).

Maternal and child health indicators - 1993

Indicator	Rate reported	Rate estimated
Infant mortality	21/1 000	52/1 000
Under-five mortality	28/1 000	N/A
Maternal mortality	95/100 000 live births	
Low birth weights (1992)	11.3%	

155. In infants, the major reasons for hospital admissions (morbidity) are: (i) respiratory disease (35 per cent); (ii) injury and poisoning (16.4 per cent); (iii) problems of the digestive system (10.7 per cent); (iv) perinatal conditions (9.4 per cent); (v) skin/subcutaneous diseases (5.7 per cent); (vi) malnutrition (4.7 per cent); (vii) congenital anomalies (4.1 per cent); (viii) intestinal infectious diseases (2.8 per cent). The same conditions are also responsible for the majority of under-five hospital admissions, especially respiratory diseases (26 per cent), followed by perinatal conditions (19 per cent) and intestinal infectious diseases (18 per cent).

156. Within the under-five year age group, males consistently had higher rates of reported illnesses.

157. Among the problems causing the high incidence of perinatal deaths and morbidity are: a high incidence of low birth weights (11.3 per cent); the increasing number of teenage pregnancies (13 per cent of total deliveries), especially in Pohnpei; and a high rate of infections. Home births without any formal medical assistance have declined from 12 per cent of all births in 1986 to 8 per cent in 1994.

158. During the same period, deliveries at medical facilities have risen from 75 per cent to 89 per cent. The late entry of mothers into the prenatal care system is also a major problem, with only 24 per cent of women making their first visit in the first trimester, and over 70 per cent not attending prenatal clinics until the second and third trimesters. Delivery of prenatal care is a major problem.

159. The medical services are affected by scarce resources and shortage of manpower, adequate services and qualified professionals. The nation spent $12.171 million on health care in 1989, representing some 14 per cent of the total budget. This translates to spending, on average, $116 per person on health care. However, this figure varies significantly by state: $96 in Chuuk, $108 in Pohnpei, $143 in Yap and $162 in Kosrae (which has few problems regarding access to health-care services).

160. However, most of the budget is expended on secondary (hospital) curative medicine and off-island referrals rather than primary health-care activities. During the period covered by the First National Plan (1987-1992), an estimated 25 per cent or more of state budgets was spent on medical referrals, although it is hard to come up with accurate estimates in either percentage or dollar terms. A primary health-care programme is only effectively operated in Yap. Most recently, the Office of Primary Health Care has been established within Pohnpei State Health Services and, with external financial support, has re-established PHC in select outer villages on Pohnpei Island and standardized PHC operations on five outer islands. Kosrae state has a community outreach programme, whereas Chuuk state at present has no well-organized community-based primary health-care activities. Where primary health-care activities have been initiated and are already effective, they have received a relatively small proportion of the available resources.

3. Implementation

161. In the FSM, communicable diseases and malnutrition are leading causes of premature deaths and suffering in children. More and more, the adverse interrelationship between infectious disease and malnutrition (mostly related to inappropriate diet rather than the unavailability of nutritious food) is being recognized and acknowledged publicly as the major health threat to FSM children. The tragedy is that most episodes of infectious disease and/or malnutrition, which lead to suffering and premature death, are treatable and/or preventable with simple and relatively low cost health-care strategies and low cost medication. To address this, a number of programmes have been developed among the FSM States to mitigate these health problems which affect both mothers and children.

162. As well as combating the "old" communicable diseases, state health services are increasingly being challenged to address the effects of the "newer" non-communicable or life-style diseases. The health of mothers is also adversely affected by poor nutrition, specifically iron deficiency anaemia and increasingly by other nutritionally-related diseases associated with over-nutrition and obesity, smoking and alcohol use/abuse. Such nutritionally related diseases include maternal hypertension, gestational and non-gestational diabetes, coronary artery disease and respiratory and liver diseases. These "new" morbidities - including vitamin A deficiency in lactating mothers - not only affect the mother's health but also have a major direct and indirect impact upon the health and well-being of the foetus, the infant and the child, contributing to foetal wastage, stillbirths, congenital abnormalities, numerous in gestational infants, birth trauma, seizures and mental retardation, premature and low birth weight babies, cerebral palsy, respiratory disease and neonatal and post-neonatal infectious diseases.

163. Malnutrition, whether from undernutrition or an inappropriate diet, affects one in eight FSM children overall. However, in certain populations, the majority of children under six years of age suffer from the effects of some form of malnutrition, particularly from vitamin A and iron deficiencies. As malnourished children, some with outright kwashiorkor, their risk of death and suffering from infectious diseases is dramatically increased and represents a burden not only to their families but also to their respective state health-care systems and to the nation as a whole.

(a) Immunization

164. The FSM Immunization Programme is a combination of the WHO Expanded Programme on Immunization (EPI) and United States Advisory Council of Immunization Practices. In addition to EPI antigens (diphtheria, pertussis, tetanus, poliomyelitis, measles and BCG), the FSM requires additional vaccinations against mumps, rubella, hepatitis B and, most recently, Hemophilus influenza type b.

165. Most vaccine coverage should be completed by a child's second birthday, with further vaccines then given at school entry. State laws require evidence of complete immunization prior to school entry.

166. The national and state immunization programmes receive special funds from the United States Public Health Service which are outside of the direct Compact funding. Immunizations to FSM residents are provided in a variety of methods, centralized-hospital and public health clinic-based activities (immunization, well baby and antenatal clinics), public health team school and community visits, and as part of general PHC activities in select dispensaries and aid posts.

(i) Constraints

167. Immunization coverage for the FSM states varies, as dramatically reflected in measles attack rates in recent years in Kosrae, Pohnpei and particularly Chuuk and Chuukese living in Guam.

168. Immunization services are in the main provided by centralized programmes at public health clinics attached to central hospitals in state capital settings. Even within the hospital setting, immunizations are generally only given in immunization clinics, during set hours, and are not generally available in busy outpatient clinics, the emergency room or after hours. Because of the centralization of immunization services, most of the population, who live outside the state centres, are denied easy access to immunization services. Immunization team visits to outer villages and atolls and their schools improve the provision of vaccines to these remote sites, but such visits are episodic. Commonly reported factors limiting universal availability of and easy access to immunization include overzealously adhered to reporting restrictions (to meet the requirements attached to United States federal immunization grants) and problems with the cold chain system and the capacity and reliability of refrigeration systems in remote villages and outer islands. Because of limited and variable access to immunization, it is impractical to enforce school entry immunization laws (non-compliance is the rule).

(ii) Solutions

169. The provision of decentralized, organized and reliable community-oriented and then, eventually, community-based PHC services by a well-trained and supervised health workforce will make immunization services (and all other PHC-associated services) available to all eligible children and adults.

(b) Diarrhoeal diseases

170. Diarrhoea is still one of the most common causes of death (8 per cent in children under five years old, 1992), hospital admissions (18 per cent of all admissions) and among the most common out-patient diagnosis (12 per cent) in all FSM hospitals. The Pohnpei Child Health Survey (1994) indicated that up to 15 per cent of children aged between 24 and 47 months had suffered from diarrhoea some time in the two weeks preceding the survey, which would indicate a higher incidence than is shown from morbidity data. There is no precise figure for the number of diarrhoeal episodes per child per year for the FSM at this time, although the child health survey data indicate that the prevalence of diarrhoeal diseases is high.

171. Oral Rehydration Therapy (ORT) or Oral Rehydration Solution (ORS) has been introduced to the FSM and its use is widespread. It is used in all hospitals as part of rehydration therapy for diarrhoeal cases and is widely distributed through dispensaries and clinics.

172. While introduction of ORT/ORS will reduce morbidity and mortality, prevention of diarrhoeal diseases will require still further investments in water, sanitation and health education.

(i) Constraints

173. Because of the lack of PHC services in most FSM communities, ORS packets and instructions how to use ORT/ORS effectively are not generally available to most of the population. Even within the centralized hospital settings, there still continues an over-reliance on the use of expensive and invasive intravenous replenishment fluids for diarrhoea and dehydration.

(ii) Solutions

174. The establishment of an effective PHC system for most of the population of the FSM will promote early access of children with diarrhoea to the health-care system and provide the capacity, within a PHC programme, to dispense ORS and teach parents how to administer it successfully. As part of a PHC model approach, promotional community education programmes should be implemented to improve personal and family hygiene and promote positive local sanitation practices. In hospital settings, protocols for the oral treatment of mild and moderate dehydration need to be implemented.

(c) Acute respiratory infection

175. In infants and children in the FSM, infectious diseases are still the leading cause of death (1986-1991: 920 deaths/100,000 population). Of these deaths, over 55 per cent are from respiratory infections. Overall, acute respiratory infection (ARI), after deaths from perinatal conditions, is the leading cause of death in infants and the most common cause of admission to hospital in the first 12 months of life (35 per cent). In 1994, in children under the age of five, ARI was the leading cause of death and the leading cause of admissions for children to hospital (26 per cent). This mortality and morbidity among children represents a significant and sad burden to the FSM community and a great cost to national and state health services, especially when it is appreciated that much of this child death and suffering is treatable and/or, in many cases, preventable.

176. Prevention strategies include the promotion of breast-feeding, complete vaccination coverage for all children (particularly those under two years old) and improving the general nutritional status of children, particularly their vitamin A status.

(i) Constraints

177. The lack of timely access to PHC services consistently contributes to this unacceptable burden of death and suffering. Most FSM infants and children who die from a respiratory infection do so because they are not

adequately immunized (pertussis and measles) and/or are brought to the attention of the health-care system too late with terminal pneumonia.

(ii) Solutions

178. Practical and achievable strategies to reduce ARI deaths and suffering in children include improved availability of PHC services, which will better assure timely and consistent access to immunization, low cost antibiotics and systematically trained and supervised PHC workers. Community health education efforts to empower parents to recognize when a fever and a cough in their children is serious (i.e. counting respiratory rates, looking for chest indwelling, etc.), before it is too late, are low cost strategies (early identification and intervention) which have proved successful and are achievable and measurable.

(d) Rheumatic fever and rheumatic heart disease

179. The incidence of rheumatic heart disease in the FSM has been found in a retrospective study to be at least 10 per 100,000 children in the age group 5-14 years old. However, the same study also suggested that the true incidence could be much higher, because of under-reporting (10 times less than the Pacific Island average rate).

180. To date, most activities have concentrated on prophylaxis for those identified as having suffered from rheumatic fever. However, recommendations are under consideration which would entail treating all "sore throats" with antibiotics as a standard practice, to prevent rheumatic fever from developing.

(i) Constraints

181. The school-aged population is most at risk of developing streptococcal pharyngitis, rheumatic fever and rheumatic heart disease. Currently, most FSM preschool and school-aged children do not have access to PHC. Except in Yap state, all strategies to identify and treat streptoccal pharyngitis, or identify and treat children suffering from the sequelae of rheumatic heart disease are implemented in centralized settings or through episodic health team visits. In both state centres and rural settings, non-compliance with prophylaxis to prevent recurrent rheumatic fever is high (compliance is the exception). Until there is an effective decentralized PHC system that identifies, treats or prevents streptococcal pharyngitis, there will continue to be a steady stream of handicapped children and adults with preventable heart disease. Currently, in the FSM, it is administratively easier to refer a child off-island for open heart surgery costing up to $50,000 than it is to provide $0.50 worth of penicillin within a PHC setting to treat streptococcal pharyngitis in time and prevent rheumatic heart disease.

(ii) Solutions

182. The solution to the problem consists in the development of a decentralized PHC system which includes effective school health programmes.

(e) Tuberculosis

183. In the FSM, tuberculosis (TB) is widespread. Infants and children suffer from excessive rates of pulmonary and extrapulmonary TB which is contracted primarily from adult carers. State TB programmes vary in their effectiveness in identifying adults with the disease in active form and in protecting children who are exposed to these adults. Only Chuuk state has a formal BCG vaccination programme for newborns.

(i) Constraints

184. Currently the risk of developing TB in the FSM population is about 1 per cent per year. Except in Chuuk, there is no BCG immunization programme and the Chuuk programme is plagued with implementation and reporting problems which seriously limit its credibility and effectiveness. Until recently, the main strategy to address the problem of TB was hospital and curative-based: wait for children and adults to get sick, admit them to hospital and treat them. In the case of children (and adults), little attempt was made to identify the family source of the disease. Once discharged, patients were then often lost to follow-up by centralized, hospital-based TB clinics. This strategy does not reduce the burden of TB on the community, rather it promotes the development of multiple drug resistant TB and ensures that children (and adults) will continue to die and suffer from this treatable and preventable disease.

185. Another constraint is the continuing confusion among FSM medical and public health professionals regarding the appropriateness and utilization of different TB identification and treatment protocols offered by a steady stream of consultants from United States and United Nations organizations who promote strategies that are often at odds with each other. Attempts at implementing national tuberculosis identification and treatment protocols have met with variable success.

(ii) Solutions

186. The development of appropriate and flexible national TB treatment protocols is achievable. The community identification and treatment of TB would best be carried out in the context of well-organized and accessible PHC services, with community workers providing directly observed therapy (DOT) and appropriate follow-up.

(f) Leprosy

187. Progress is being made in leprosy control, with case numbers fairly steady (small increases are thought to be due to better tracking and screening). Currently, 189 of the active leprosy cases in FSM out of a total of 380 - 50 per cent - are children under 20 years of age. Kosrae and Yap have only 11 cases between them, whereas Chuuk and Pohnpei have 73 and 105, respectively.

(g) Malnutrition, including iron deficiency anaemia and vitamin A deficiency

188. Between 1986 and 1991, according to FSM statistics, malnutrition matched ARI as a leading cause of death in children under five years of age. Although the health indicators data are accepted as being under-reported, the relationship between malnutrition and infectious disease, particularly death from ARI and acute gastroenteritis, is well recognized. In the FSM, malnutrition in most infants and children is not because of the lack of availability of nutritious foods within the FSM but usually because of a growing parental preference or lack of knowledge which includes the underutilization of breast-feeding and a departure from the local diet. Common dietary histories of children with kwashiorkor and severe vitamin A deficiency (VAD) in the FSM include rice only diets.

189. The 1987-1988 National Nutrition Survey revealed that the nutritional status of many infants and young children in the FSM was poor. One in eight FSM children was noted to be nutritionally at risk. Early weaning and inadequate or unsuitable weaning foods were to blame. Generally the growth of children up to six months of age was good, with higher than expected breast-feeding rates. However, after six months of age, weaning from breast and/or bottle milk was too early (7-9 months) and by 12 months most children were solely on solid foods. The survey indicated that, in general, the amount of food, not the type of food, was the important factor.

190. In 1994, surveys made on selected Pohnpeian children between 24 and 47 months old revealed that there was a 25 per cent prevalence of children with weights below the fifth percentile and that 33 per cent of the children had a haemoglobin level under 11.5 grams per cent. In comparative and age adjusted serum vitamin A (and vitamin A precursor) studies made of selected children in both Pohnpei and Chuuk, it was noted that 51 per cent of Pohnpeian children and 63 per cent of Chuukese children evidenced moderate to severe VAD. These studies were consistent with previous studies in Chuuk (CDC, 1992, unpublished) in which up to 96 per cent of serum samples of selected child populations showed moderate to severe VAD, 79 per cent of the children showing serum retinol levels which put these children at greater risk of severe debilitating disease and possibly death. Other, UNICEF, studies in Chuuk (1989) showed up to a 17 per cent Bitot spot detection rate, a late indicator of VAD, which is 11 times the acceptable maximum community rate for Bitot spots set by WHO.

191. Chuuk and Pohnpei states are comprised, for the most part, of lush fertile islands, with abundant fish in the surrounding lagoons. It appears from the low birth weight, VAD and low haemoglobin rates, that appropriate local foods are not consistently reaching a significant proportion of children in these two states.

(i) Constraints

192. Impediments to good nutrition in FSM children include too early weaning from breast-feeding, a growing dependence on expensive imported western foods

and the adoption of inappropriate eating patterns which exclude iron rich proteins and vitamin A. There is a dearth of vigorous local food markets, which is both a result of the importation of more than likely expensive but less nutritionally rich foods and causes further dependency upon them.

(ii) Solutions

193. Strategies to address malnutrition among FSM children include promoting breast-feeding, appropriate weaning strategies, the genuine implementation of progressive and organized client education programmes at antenatal care and well baby clinics, community education through health education programmes in the schools, churches and women's groups, and through the efforts of international community service organizations and projects such as the UNICEF-funded Family Food Production and Nutrition Projects throughout the FSM and the emergency stratagem of the Chuuk/UNICEF vitamin A deficiency and Vermox (VADAV) campaign. The acceptance by FSM health and political leaders of the fact that malnutrition in children in the FSM is a serious problem has been the first step to developing and implementing both emergent and long-term solutions to malnutrition in FSM children.

(a) Iron deficiency anaemia

194. The opportunities for improving the situation with regard to iron deficiency anaemia (IDA) are complex. Iron supplementation of pregnant women is a short-term solution requiring a high rate of prenatal visits of at least four visits per pregnancy. Currently, most pregnant women are receiving iron supplementation during pregnancy though prenatal care attendance. Compliance is not sufficient for the programme to be effective, with over 70 per cent of pregnant women not attending until the second and third trimesters). In the long term, the access of all children, but particularly young girls and women, to iron rich sources of food needs to be improved through dietary diversification and health education on good sources of iron in the diet.

(b) Vitamin A deficiency

195. Vitamin A deficiency (VAD) rates are excessive in the FSM (see table below). Besides contributing to blindness, VAD is thought to heavily contribute to the high death rates associated with respiratory infections and acute gastroenteritis in FSM children. In 1994, the excessive death rates from measles in Chuukese children and in adults in both Chuuk state and on Guam were also thought to be VAD-related. The results of the recent Child Health Surveys in Chuuk and Pohnpei (1994) and the previous VAD survey in Yap (1993) clearly indicate that a much higher proportion of children are at nutritional risk - with a much higher risk of death and suffering - than previously estimated in the FSM Nutritional Survey (1987/1988). VAD in lactating mothers also puts their babies at even earlier risk of VAD and its consequences. VAD, associated with high rates of ARI and diarrhoea, is a profound threat to the health and well-being of FSM children.

FSM vitamin A deficiency studies - 1985-1994

Year	Group	State/findings
1985	Lloyd-Puryear	Chuuk: 50% of outpatient children screened at Chuuk State Hospital with abnormal vitamin A levels
1987	PBMOTP/JABSOM	Chuuk: 18% children (0-12 years) screened with Bitot's spots; 15% frequency among children 0-6 years
1989	UNICEF/FSM	Chuuk: 17% clinical VAD rate among children screened
1992	Mahoney/CDC	Chuuk: 96% VAD rate in children (serum retinol blood samples)
1993	Lloyd-Puryear/CDC	Yap: using conjunctival impression cytology, 25% children screened on Yap proper abnormal, 40% abnormal on outer island of Woleai
1994	FSM Child Health Survey	Chuuk: 63% children screened (serum) with VAD Pohnpei: 51% children screened (serum) with VAD

(i) VAD solutions

196. The FSM, in consultation and collaboration with UNICEF, has developed a state-wide vitamin A deficiency and vermox (VADAV) campaign which has been implemented in Chuuk twice a year, during the third week of September and the third week of March, since 1993 and will be implemented every year for the next 10 to 15 years. This targets all children between the ages of 1 and 12 and aims to give each child a vitamin A capsule containing 200,000 IU of vitamin A (sufficient for six months) and a dose of vermox to reduce intestinal parasites. To date, approximately 13,000 children have been reached in the first phase of the campaign. This strategy may be effective in the short term, but the long-term goal is to increase the dietary intake of vitamin A rich foods.

197. In Pohnpei, which has not initiated a universal VADAV campaign like Chuuk, in-patient and out-patient protocols are being developed to treat infants and children who demonstrate nutritional risks (under weight, IDA, Bitot spots, etc.) with maintenance or therapeutic doses of vitamin A.

198. FSM states are making genuine efforts to capture the attention of public and political leaders and break through the denial that malnutrition, and specifically VAD, is a serious threat to the health and well-being of FSM children. Long-term nutritional strategies are being developed to supplant short-term emergent treatment campaigns in order to reduce VAD again to negligible levels in the FSM.

(h) Low birth weight

199. Low birth weight babies accounted for approximately 11.3 per cent of total newborns in FSM and contributes to the excessive infant and under-five mortality rates in the FSM. Opportunities for decreasing the number of low birth weight births, based on the previous assumptions as to the causes, are many. Improved and earlier attendance at prenatal clinics gives a chance of early intervention in high-risk pregnancies. Increased access to family planning allows women to have more control over the number and spacing of pregnancies and reduces the number of teen pregnancies. Improved maternal nutrition ensures a healthier mother, more likely to give birth to a normal weight, healthy child.

(i) Constraints

200. In 1993, only about 24 per cent of women made their first prenatal visit during the first trimester. Late entry of mothers to prenatal care is a chronic problem, with more than 70 per cent entering in the second and third trimesters of pregnancy. Except for Yap, and only most recently in select dispensaries on Pohnpei, all organized ANC services in the FSM are provided at centralized public health clinics attached to hospitals in the state centres. The prenatal system either does not identify, or identifies too late, the majority of mothers who are nutritionally at risk (overweight, underweight, anaemic) during their pregnancy.

201. Contributing to the rate of low birth weight babies is the increasing number of teen pregnancies, particularly in Pohnpei and Yap. Excessive high school drop-out rates and few employment opportunities or youth activities contribute to the high teenage pregnancy rates and ultimately to the excessive infant mortality related to low birth weight (and the low educational attainment of mothers).

(ii) Solutions

202. Decentralization of the prenatal services would improve the availability of, and access by the community to, such services. This system would then be linked to high-risk prenatal services either by sending the few patients concerned to high-risk pregnancy clinics in hospital settings or by having health-care workers familiar with the management of high-risk prenatal patients periodically visit community dispensaries, where logistically possible. Encouraging teenagers to finish high school (where issues of family planning can be discussed), providing meaningful youth programmes (including health education) and developing improved employment opportunities are strategies which may also decrease teenage pregnancies and reduce the numbers of low birth weight babies and the infant mortality rate.

(i) Breast-feeding

203. Breast-feeding is endorsed by both the national and state governments as being the best and only food for infants up to the age of from four to six months and as being a practice that should be continued for children up to two years of age. Public health nurses promote breast-feeding at prenatal clinics and this is followed through by hospital nurses after delivery and before

mothers leave the hospital. Almost 100 per cent of mothers who give birth in hospital breast-feed their infants from birth until discharged from hospital. Breast-feeding education is continued by public health nurses at post-natal and well baby clinics. The nutritional requirements of the lactating mother need to be addressed, especially with regard to vitamin A and iron, so as to protect solely breast-feeding infants from VAD and IDA.

204. The UNICEF/WHO Baby Friendly Hospital Initiative and Promotion of Breast-feeding has now been introduced in the FSM. A breast-feeding policy has been signed by the Secretary of Health and all four state Directors of Health, and the "10 steps" towards a baby friendly hospital are being implemented by Pohnpei State Hospital in a pilot programme. There is also the greater need to develop community-based baby friendly programmes throughout the FSM.

(j) Suicide

205. Suicide among FSM citizens, including children, adolescents and young adults has reached epidemic proportions. In the FSM, in 1960, a total of two suicides was recorded (all ages). Between 1960 and 1994, the total number of suicides had risen to 531 (all ages). Since 1985, among children and adolescents under 15 years of age, there have been 32 suicides. In the same period (1985-1995), the total number of suicides for ages under 21 has been 133 children, adolescents and young adults (see table below). Overall, since 1985, of the 233 suicide deaths in FSM residents under age 31, most of the deaths (57.1 per cent) have been of children and adolescents (<15 years: 13.7 per cent) and young adults (16-20 years: 43.3 per cent).

Suicide in FSM by age group (1985-1995)

Age	Chuuk	Kosrae	Pohnpei	Yap	FSM total
< 15	20	2	6	4	32
16-20	61	6	21	13	101
21-25	31	4	18	13	66
26-30	20	1	7	6	34
> 31	18	2	10	8	38
Totals	150	15	62	44	271

206. In 1960, the suicide rate (all ages) in the island countries that now comprise the Federated States of Micronesia was 3.1/100,000. For the period 1991-1995, the annual average suicide rate (all ages) in the FSM was 27/100,000, which is a ninefold increase since 1960, and is one of the highest suicide rates in the world. Age adjusted, the highest rates of suicide are in the 16 to 20 year old age group (about 80/100,000). The suicide rates are very alarming for FSM children and adolescents, which is a matter of urgent concern.

207. The causes of suicide in the FSM are multifactorial. However, it is thought that changes in the extended family system are the number one contributing factor. Although the old-fashioned family structure may have furnished a tight authority system, it also provided older people with whom young men and women could talk to about their problems. This counselling and support system appeared to be built into family systems throughout Micronesia (including Palau and the Marshall Islands). It is thought that this supportive role has changed and that it is difficult, given the dramatic changes within Micronesian society since the Second World War, "for a troubled young person to find an ear within the family today, and many do not feel comfortable seeking help outside the family to talk to about problems with their parents".

(i) Constraints

208. With changes occurring in the cultural counselling system found in the extended family, and with parents tending to be more caught up with work, community functions and other personal activities, youths today tend to be less open about sharing their problems with their parents. In a 1991 youth survey conducted in the public high schools of Pohnpei and Kosrae, it was revealed that youths are most comfortable sharing their problems with other youths, rather than with their parents.

209. A 1992 FSM behavioural risk survey of 6,450 adolescents demonstrated that 27 per cent of all those surveyed had had suicidal thoughts in the previous 30 days. Often, male respondents mentioned hanging as a possible means of suicide. Female respondents mentioned drug-overdose as an easy method.

210. Family members report that relatives who committed suicide were drunk or drinking shortly before or at the time of the act 50 per cent of the time. Patients hospitalized after suicide attempts report that they were using alcohol or drugs before or during the attempt.

(ii) Solutions

211. (i) Start youth peer counselling groups in the high schools where, apparently, most of the youth suicides occur.

(ii) Strengthen community awareness programmes on alcohol and suicide prevention. Work through churches, schools and hospitals.

(iii) Start a parent training programme on drugs and alcohol and on how to counsel their children regarding their problem and needs.

(iv) Institute a telephone hot line for distressed people who need to discuss suicidal ideation (all states).

4. Environmental status

212. FSM children are growing up in a fragile ecosystem, one with a number of pressing environmental problems, including the provision of safe drinking

water supply, solid waste disposal and the disposal of domestic and commercial waste water. There is also coastal degradation and resource depletion, particularly in reef and nearshore areas. Many of the problems are exacerbated by the overcrowding and poor sanitary conditions on the more populated islands. Many of the health problems in the populations of FSM are related to poor sanitation and hygiene and unsafe water supply, which contribute to the excessive rates of death and suffering among FSM infants and children. Efforts are being made at the national and state levels to improve the overall environmental health and well-being of FSM citizens.

(a) Water supply

213. The majority of urban households in each state have access to piped water systems, but for rural households, their individual water systems consist of rain catchments, supplemented by supplies from rivers, wells, springs and streams. Few rural community water systems have a filtration and chlorination process preceding water distribution. However, master plans for water supply development have been prepared and, as a first step, rehabilitation programmes are already well under way for water systems serving the urban areas.

(b) Sanitation

214. In Kosrae, although about 50 per cent of government and school housing has septic tanks, most housing is serviced by either pit latrines or water seal toilets.

215. In the state centre of Pohnpei (Kolonia), most of the houses are connected to the municipal sewer system. However, most dwellings utilize pit latrines or water seal toilets while a few houses have septic tanks. In rural Pohnpei, where most of the population live, the majority of houses have pit latrines or over the water toilets. A small percentage of the houses have water seal toilets or septic tanks. In the outer islands, where about 10 per cent of the population live, there is a growing utilization of water seal and septic tank facilities. However, because of the proximity of the water lens and the ease with which it is polluted by any sanitation facilities, there is a greater reliance upon water catchment systems.

216. In Chuuk, on the state centre island of Weno, which is densely populated because of migration from the outer islands and particularly during the day when commuters from the lagoon islands come to Weno to work, government housing and a few private homes are connected to the municipal sewer system. Most of the houses employ pit latrines or water seal toilets and a few utilize septic tanks. In the Chuuk lagoon islands, most of which are of high volcanic origin, the majority of houses have pit latrines and water seal toilets, with only a few houses using septic tanks. In the outer atolls at Chuuk, most houses use water seal or over the water toilets. Because of the fragility of the water lens on these low atolls, the utilization of water catchment systems is increasing.

217. In the state centre of Yap, Colonia, government housing and a few private homes are connected to the municipal sewer system, with most houses utilizing

pit latrines and water seal toilets. The pattern in the outer atolls of Yap is similar to that in the rest of the FSM atolls, where most houses have pit latrines and water seal toilets. Similarly, water catchment systems are increasing in use in the outer atolls.

(c) Solid waste disposal

218. Solid waste disposal is a severe problem not only because of the danger to health but also because of the increasing costs of disposal. The problem of littering is not limited to state urban centres, but has extended to rural and outer island municipalities. Throughout all the states, a need exists to educate the population on issues of sanitation and the maintenance of a clean and healthy environment.

219. With the exception of Yap in its state centre (Colonia), no organized collection system operates in the FSM, although such a system is planned for the state centre of Pohnpei (Kolonia). Refuse is not collected and transported on a reliable basis, except in Yap (Colonia) which has a proper refuse truck but its collection system is in need of improvement. In general, state ordinances, regulating the methods of handling refuse from collection to disposal are not enforced. As a result, some of the roads are littered from private refuse trucks. State governments do not maintain proper sanitary landfill sites, which in three states are part of the lagoon and in one state is situated in near proximity to the municipal water source.

(d) Constraints

220. Both the geographical and geological make-up of the high and low islands and atolls of the FSM, which are spread over a million square miles of Pacific expanse, frustrate the equitable improvement of water, sanitation and solid waste disposal. Additionally, effective implementation of sanitation procedures is hampered by lack of resources - both in trained personnel and funding. Traditional land ownership issues also are impediments to the selection and implementation of solid waste disposal sites.

(e) Solutions

221. A higher prioritization of environmental health issues, particularly regarding water, sanitation and solid waste disposal needs to be developed and implemented including the training of an effective environmental health workforce and the further introduction of environmental health into the school curriculum. Additionally, there need to be developed community oriented and based environmental health education programmes to improve the knowledge, attitude and skills of the public at large regarding the issue of environmental degradation and the promotion of environmental well-being. One specific solution may include the privatization of water, sanitation and solid waste disposal systems in selected states. There also needs to be more aggressive monitoring and enforcement of environmental protection statutes which protect marine habitats throughout the FSM, particularly against the dumping of sewage, oil and chemicals by foreign vessels and local fishermen in state harbours and lagoons and on the fringe reefs.

Article 23. Disabled children

1. Children with special health-care needs

222. In 1991/1992 the Maternal and Child Health Tracking Programme for Children with Special Health Care Needs (CSHCN) recorded a total of 1,162 children (624 males and 506 females, 32 unknown) with special needs. The disabling conditions included in the CSHCN programme are birth defects/congenital anomalies, acquired disabilities, perinatal complications, rheumatic heart disease, tuberculosis, chronic otitis media and vitamin A deficiency.

223. On the basis of figures for the expected number of children with special needs (from United States data), it is apparent that there is probably a need for increased identification of children with less severe conditions (expected rate 6,000 children, compared to an identified 1,162). However, the rate of off-island referrals for children with severe disabilities (265 between 1985 and 1986) is consistent with the expected rate (256), indicating better management of these cases. The majority of needs for specialty consultation are for cardiac problems (often related to rheumatic heart disease), followed by orthopaedic conditions.

224. There are no specialists within the FSM to deal with most of these conditions and children are dependent on off-island referrals and visits from specialty teams, who come perhaps once a year.

2. Children with special educational needs

225. The FSM through each state department of education, has available educational programmes for eligible children with disabilities. Such programmes are established, reviewed and required by both state and national legislation. The department of education in each state, under the coordination of the National Department of Education, is responsible for ensuring that individual education plans (IEPs) are developed and implemented for each child with a disability.

226. Procedures are adopted by the FSM Department of Education for ensuring that handicapped children and their parents are guaranteed procedural safeguards in decisions relating to identification, evaluation and educational placement.

227. The FSM Department of Education, through the state department of education, has established procedures to ensure that, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other facilities, are educated with children who are not handicapped and that special classes and separate school placement occur only when the nature of severity of the handicap is such that education in the regular classroom with supplementary aids and services cannot be achieved satisfactorily.

FSM students identified as disabled - 1995

Type of service	Chuuk	Pohnpei	Yap	Kosrae	FSM Total
Mental retardation	76	25	10	5	116
Hearing impairment	273	13	2	3	291
Speech language impairment	114	13	2	1	130
Visual impairment	136	32	8	0	176
Serious emotional impairment	56	23	4	0	83
Orthopaedic	69	8	8	1	86
Other health	15	0	50	0	65
Specific learning diagnosis	640	1 266	195	181	2 282
Deaf and blind	8	4	1	2	15
Multiple disabilities	65	12	7	4	88
Autism	0	0	0	0	0
Traumatic brain injuries	0	0	0	0	0
Totals	1 452	1 396	287	197	3 332

Special education funded employees - 1995

State	Number of employees	Salaries
Pohnpei	77	$683 126
Kosrae	40	$294 382
Chuuk	45	$250 023
Yap	N/A	N/A
Sub-total states	207	$1 227 535
National Government	4	$59 925
Total	211	$1 287 460

Note: About 32 per cent of the grant total is used for salaries.

Article 26. Social security

228. Fifty-three FSMC creates the FSM Social Security Act. The purpose of the Act is to provide a means whereby persons may be ensured a measure of financial security in their old age. Additionally, children of wage-earners who are deceased are provided with survivor's benefits.

Article 17. Standard of living

229. As the economy continues to move towards a cash-based system and away from a subsistence-based one, the children of the FSM are affected in a variety of ways. The most significant factor is the income of each household and the amount spent on its children. Children's welfare is affected by the amount of funding the national and state governments are able to provide for social, health and educational programmes. At present, all these programmes are funded primarily by United States Compact funds which will continue to decline over the next few years, before they finally end in 2001. The private sector has not yet expanded sufficiently to be able to replace the Government as the major employer and income provider.

230. Despite many new opportunities with the potential to improve the well-being of children, there are new challenges for FSM children in their rapidly changing world. Although the calculated population growth rate for the FSM is 2.1 per cent (1994), which is modified by the out-migration of mostly FSM adults, the FSM birth rate is still over 3 per cent. Either rate (birth or growth) means that for each child living today, given the current economic status of the FSM, there is less land, less money and less of other resources (health and education), than for the children of past generations. While the population is growing rapidly, and at the current rate (assuming the opportunity for out-migration will continue beyond the current Compact term) will double in just over 30 years, economic growth in the past decade has not kept pace. This means that the economic well-being of many families has not improved despite rising expectations, for many rural families, declining agriculture commodity prices (particularly copra) has meant declining cash income.

231. Government has a declining amount of funding available owing to the reductions in the Compact funding. This has meant that expenditures on health, education and other social services have been reduced or have failed to keep pace with the growth in population. Children, particularly in lower income and subsistence families, suffer most as a result of economic difficulty.

232. In 1989 the ratio of imports to exports in FSM was 15:1. However, by 1994, this ratio had decreased dramatically to 2.2:1 (FSM Trade Bulletin, 1994). Clearly though, in spite of these dramatic import-export ratio improvements, the FSM economy would not be sustainable if the Compact funding was not available. According to the 1988/89 National Survey of Household Income and Expenditure, the national average disposable income per household was $107.31 per week; and the income per person was $16.36 per week (over half of the nation's households had seven or more members). The percentage of households with zero income (zero cash income) was 16.1 per cent although this varied greatly from state to state. For example, Kosrae with a small

population and relatively easy access to commercial and employment centres had only 4.5 per cent of its households with a zero income. There are major inequalities in the distribution of wealth both between states and between people within states.

233. If median incomes are lower than the estimated mean income, which is the case in FSM, it indicates that the income distribution is skewed towards high income earning households.

Income per person from all sources by state (dollars per week)

State	Mean	25%	Median	75%
Chuuk	10.25	1.78	4.67	12.91
Kosrae	20.73	5.56	12.67	25.40
Pohnpei	16.14	1.18	8.50	20.82
Yap	34.53	3.75	16.06	35.01
FSM total	16.36	2.50	8.84	21.94

Source: SNDP - 1991.

234. The average weekly expenditure per household was $106, of which 50 per cent was spent on food purchases (37 per cent on imported foodstuffs such as rice, canned fish, canned and frozen meat and turkey tails; 12 per cent on locally produced food), 4 per cent on beverages and 5 per cent on tobacco. Amounts of food bought per person were similar in all states with an average weekly household expenditure per person in Kosrae of $8.10, Pohnpei $7.10, Chuuk $6.40 and Yap $7.40. Food, in particular imported food, is the main expenditure item in every state.

Total imports of goods and services by FOB value and major standard international trade classification

	1989	1990	1991	1992	1993
Food	17 318 665	20 309 196	23 794 687	19 752 057	31 170 468
Machinery and vehicles	11 691 422	12 542 759	12 508 805	16 792 638	22 086 048
Manufactured goods	12 236 979	11 500 142	12 757 481	13 873 224	18 503 253
Miscellaneous goods	6 848 175	7 925 160	8 218 441	7 619 414	12 955 493
Petroleum products	7 182 327	14 485 269	11 691 644	16 895 834	11 221 366
Beverages and tobacco	7 394 289	8 873 560	8 549 492	8 048 133	7 035 376
Chemical	3 307 827	3 797 652	3 661 363	4 416 106	4 245 021
Item NEC	6 537 764	4 160 138	7 314 900	11 326 523	2 166 188
Crude materials	182 193	225 178	133 714	59 768	99 452
Animal and vegetable oil	25 148	60 966	103	12 688	3 648
Total	72 724 789	83 880 020	88 630 630	98 796 385	109 486 243

Source: OPS Statistical Handbook, June 1995.

235. There is a strong social emphasis on sharing wealth. Traditionally, this has meant sharing agriculture products and in labour intensive projects, but as the cash economy becomes more dominant, sharing now involves money and imported goods, in addition to locally available produce.

Constraints on basic health and welfare

236. The three main themes which constrain the effective protection of children's basic health and welfare are: (i) high population growth; (ii) declining development finance; (iii) impediments to the development of basic and secondary health-care infrastructure.

1. Population trends

237. Overall, the population is increasing, with a birth rate of over 3 per cent, which means that by the year 2000 the population will have increased by more than 40 per cent (assuming past fertility and mortality levels). Population projections indicate that in the next 10 years there will be more than 4,400 children under five years - an increase of 26 per cent. Those children already born (in the age group 1-4 today) will increase the number of children seeking school places by 3,200 - an increase of 23 per cent. And there will be 4,800 more youths (15-19 years old) looking for jobs or advanced education - an increase of 44 per cent. Essential services will need to expand to keep pace with this rapid increase, if the current situation is to be maintained.

238. Out-migration of mostly adults to the United States is a continuing option under the terms of the Compact and provides an important safety valve, although there are important social consequences to both the FSM and the receiving area (Guam, Hawaii or certain areas of the mainland United States. When out-migration figures are considered, the overall annual population growth rate of the FSM declines from over 3 per cent to 2.1 per cent (1994), but out-migration may not always be an option once the Compact terminates in 2001.

239. Like many less developed countries that are experiencing rapid growth and development, progress has been made in reducing the mortality rate. However, there is often a lag time between the reduction in the mortality rate and a decline in the fertility rate, a situation in which FSM finds itself at present.

2. Economic trends

240. While government revenues per capita are currently approximately $1,909, these could decline to less than one quarter of this amount early in the next century, depending on the status of Compact funding after 2001. Estimates of GDP made in 1989 were $1,467 per capita, but this varied from state to state:

GDP per capita by state - 1989

State	GDP per capita
Chuuk	$1 046
Kosrae	$1 989
Pohnpei	$1 748
Jap	$2 107
FSM	$1 467

241. In spite of the improvement of the import-export ratio, the FSM has a limited resource base, high dependency on external aid and the government sector, a serious imbalance of trade and limited development of the private sector outside the retail/wholesale sector.

242. Structural adjustments will be necessary over the next few years, given the decrease in revenues from the United States. Options include: reform of the government, changes in the taxation system and commercialization of government activities; also continued efforts to promote exports and tourism, although import substitution will be of equal or greater significance.

3. Development plans

243. Against the backdrop of population and economic constraints, the Second National Five Year Development Plan (1992-1996) highlighted eight themes as areas on which to concentrate future development efforts: economic development; human resources development; national unity; efficiency in government; cultural development; equity; quality of life; and youth.

244. Some of these themes in the Second Five Year Development Plan have direct relevance to the situation of children in FSM, and are directly quoted below:

> Human resources development - Education and training have been much neglected in the past, and more attention needs to be devoted to these issues at all levels - elementary, secondary, post-secondary and vocational.
>
> Cultural development - When change takes place, traditional and cultural values and skills often disappear. Fortunately, such values and skills are still widely held and known in the FSM and all governments are determined to build on their strengths.
>
> Equity - There is a need to ensure that development opportunities are widely distributed, that policies are introduced to reduce the income differences between states, and that the problems of women and the poorer sections of the community - particularly the outer islands - are properly addressed - including access to basic health care and the equitable distribution of the health dollar to all FSM citizens.

Quality of life - A clean environment, adequate shelter, appropriate health and social services, a balanced diet and the ability to make political and economic choices all contribute towards the quality of life.

Youth - The greatest increase in domestic population over the next few years will involve the 15-24 age group, which will account for more than 50 per cent of the population increase from 1990 to 2000. The provision of education, training and recreational programmes, which will equip young people to deal with the complexities of modern life and an increasingly international environment, will therefore be a major focus for policy development and policy implementation.

245. While these statements show promise in their intention to provide children and youth with greater resources, there is a great need to develop these themes into action.

4. Organization of health services

(a) Variable access to primary health care - an issue of justice and equity

246. Currently, in the FSM the majority of the state health-care budgets are spent on centralized hospital care and off-island medical referral services. This leaves inadequate funds both for the infrastructure development of decentralized primary health-care services and the upgrading of secondary health-care services. Although dated, information (WHO) for 1988 indicated that 9 per cent of FSM per capita GNP was expended on health. Of this, in 1990, 0.01 per cent was devoted to local health services. Additionally, the categorical nature of external funding, often driven by United States federal grants, promotes fragmentation of services and the inefficient utilization of the health workforce. The net result is that (i) the health-care dollar is largely expended on a few residents to the exclusion of the majority of residents - including most mothers and children, who collectively make up the majority of the FSM population and (ii) whatever funds are available are not efficiently utilized.

(i) Primary health-care development

247. As most of the populations within the FSM States live away from the state centres in remote villages and isolated atolls, access to PHC ranges from non-existent to episodic in three states, to reliable and good in a fourth state. Basic, decentralized, organized and reliable PHC services are generally not available for the vast majority of the population of the FSM. This simple fact contributes to an over-representation of infant and child mortality and morbidity for largely treatable and/or preventable diseases which otherwise could be dramatically reduced by the provision of low-cost health technologies and strategies which include immunizations, oral rehydration solutions, low-cost antibiotics, the collective promotion of breast feeding, local diets, child-spacing and family planning and the empowerment of families with timely and practical health education.

(ii) The impact of off-island medical referral

248. Before the Compacts of Free Association were initiated - for almost two generations - the practice of off-island medical referral initiated by the Trust Territory administration had expended, in some cases, up to 50 per cent of selected Micronesian country health-care budgets on less than one per cent of the population. In the FSM the cost of off-island medical referral, over time, has been a contributory factory to the chronic underdevelopment of both primary and secondary health-care services. As a result, the community's lack of confidence in the ability of the health-care system to meet its basic needs has become a political driving force increasing the pressure to promote more expensive off-island referrals and thus ensuring the continued underdevelopment of basic and secondary health services for all FSM residents, particularly mothers and children.

249. Genuine efforts are being made at both national and state levels to promote PHC, decentralize health-care services, improve secondary health-care services and grapple with the politically charged issues of off-island medical referral. However, decreasing Compact funds, the drying up of non-Compact United States health resources and the continuing and increasing community and political pressure for off-island medical referral may frustrate the realization of improved community access to PHC and actually cause the recentralization of health-care services - both of which will have a continuing and adverse effect upon the health and well-being of mothers and children.

(b) Human resources for health: health workforce shortages, undertraining and lack of recognition

250. The most valuable component of a country's health-care services is its health workforce, like those of the rest of the former Trust Territory countries, the FSM health workforce, over the years, has experienced chronic shortages, the lack of consistent access to effective continuing medical education (CME) programmes, the absence of professional career tracks, overwork and underpay.

(i) Categorical funding and health workers

251. The FSM health workforce is generally understaffed. For maximum efficiency, there is a need for the workforce to be composed of generalists, skilled at a multiplicity of health workforce tasks adapted to the health-care needs of the community. Because of the nature of external funding or the overzealous interpretation and/or implementation of such funding, categorical programmes have developed in the FSM which have promoted the development of specialized and narrowly focused health personnel who do not provide general services or who, when not involved in their categorical clinics, are not available for general health-care responsibilities. Likewise, categorical clinics become impediments to availability of and access to the services they are designed to provide: in immunization and tuberculosis clinics provided at centralized locations, routinely, clients are not afforded access to these services in any other centralized settings (hospital outpatient, emergency room) nor are such services conveniently provided to the rest of the population at rural and remote dispensaries. The State Health Services

cannot afford the luxury of developing a specialized health workforce with limited focus whose members, when not providing their specialized services, often driven by external funding, sit behind a desk and do not provide services outside of their "job description".

(ii) The physician workforce

252. After the Second World War, Micronesians from the Trust Territory were sent to the Fiji School of Medicine for training as physicians, receiving a Diploma in Surgery and Medicine (DSM). After a two-year internship back in their home island jurisdictions, they then became general medical officers. However, unlike their South Pacific Islander classmates at the Fiji School of Medicine, the Micronesian physicians were generally not offered the opportunity under the Trust Territory administration to matriculate in formal diploma and master's postgraduate training programmes in either the clinical or community health sciences. Because of this, under the United States administration, Micronesian health-care systems became heavily dependent upon expensive and short-term expatriate physicians. Also, unlike their indigenous counterparts from the rest of the Pacific Islands, Micronesian physicians from the Trust Territory were not generally offered any career tracks. The net result of no postgraduate training and the lack of a career track system created what the administrative authority treated professionally as a second-class physician workforce, especially in terms of salary and career opportunities.

253. For a number of reasons, over the past 30 years, very few Micronesian students have graduated from either regional or metropolitan medical schools. This fact, combined with the retirement of the original cohort of Micronesian physicians who graduated from the Fiji School of Medicine, has led to expensive reliance upon expatriate physicians, who, until very recently, comprised the majority of the regional physician workforce in the FSM.

(a) Solutions

254. In 1986, through the infusion of United States federal funds, the Pohnpei-based Pacific Basin Medical Officers Training Programme (PBMOTP), conducted by the University of Hawaii, was established with the mission to train a new generation of indigenous physicians. Based on the Fiji School of Medicine diploma model, the five-year training programme developed a community-oriented curriculum and training process from which to date 37 Micronesian and American Samoan physicians have graduated, 29 of them from the FSM. These FSM graduates include the first ever women physicians (nine) from the FSM. By the time the programme ends in 1996, owing to its sunset funding legislation of the United States Congress, about 74 physicians from the region will have graduated from the PBMOTP, 48 of whom will be from the FSM States. Unlike the previous graduates of the Fiji School of Medicine, PBMOTP graduates will participate in formal postgraduate training activities now or soon to be available at the Fiji School of Medicine. Soon there will be adequate numbers of general medical officers to address the traditional and new morbidities prevalent in the FSM and, with time, FSM physicians with specialist qualifications (including family medicine and community health) will diminish the country's expensive dependency upon expatriate physicians. The academic and hospital and community-based PBMOTP training process is

heavily weighted towards maternal-child health disciplines and the training skills to train and retrain the community health workforce. The following table summarizes the current and projected numbers of PBMOTP graduates by country.

255. Unmet professional needs for the physician workforce include the need for continuing medical education (CME), which is non-existent in most of the isolated jurisdictions of the Western Pacific. In an attempt to address this, the Pacific Basin Medical Association was established in 1995 to become both a forum for addressing physician professional issues and a vehicle for CME. Low-cost technological advances in communications, distance learning and telemedicine are now being introduced in selected FSM islands. In the near future, with better availability of distance learning opportunities, access to regular formal CME, appropriate to the health-care needs of the region, will become a reality, not only for the physician workforce but also for the rest of the allied health team.

Total projected number of physician graduates 1992-1996:
73 (41 males/32 females)

Country	Year graduated totals					
	1992	1993	1994	1995	1996	Totals
FSM	13	8	8	9	10	48
Chuuk	3	4	3	3	4	17
Kosrae	3	1	1	2	2	9
Pohnpei	4	2	1	2	2	11
Yap	3	1	3	2	2	11
Palau	2	0	1	2	7	12
Marshall Islands	0	0	2	2	2	6
American Samoa	0	0	3	1	3	7
Male/Female	10/5	4/4	8/6	11/3	8/14	41/32
Total	15	8	14	14	22	73

(iii) Nursing

256. Under the Compact of Free Association with the United States, the priority allocation of the decreasing funds was for stabilizing the governmental structure, strengthening the economy with emphasis on private industry and improving the education and health systems. Budget cuts meant a "freeze in hiring", shortage of medical and pharmaceutical supplies and, in the case of Kosrae, a four-day work week. Thus, graduate nurses are faced with less manpower, running out of supplies, and less time to provide the same level of care expected by the people, health administrators and politicians.

257. The construction or renovation of hospitals in each state centre has been accompanied by the introduction of newer equipment, higher technology, new language and/or different standards of care. In addition, United States Public Health Service Corps and other contract physicians provide services in line with western expectations and values. Islanders tend to equate high technology and off-islanders with "being better" and of providing a higher quality of care. In order to meet the expectations of society, the off-island physicians, health administrators and ultimately the graduate nurses themselves must acquire more depth and breadth in the knowledge and skills of nursing practice. Nurses need to communicate and provide care transculturally, and still be knowledgeable and sensitive to their own acculturation processes with western values and lifestyles. In addition, the health of the community needs to be monitored more carefully during these times of change.

258. The introduction of prepaid health insurance places greater accountability on the health-care system and the nurses. People demand higher levels of care and satisfaction when they pay out money; dissatisfied clients often demand "off-island referrals" for medical care or seek the aid of lawyers, who have been increasing in numbers. Again, nurses must be astute in the legal ramifications, and practise according to established standards and policies, coupled with skilful communication to maintain good interpersonal relationships.

259. As a consequence of political, societal, economical and cultural changes, trends in diseases and health conditions have also changed. Nurses are dealing with increased numbers of maternal-child health concerns, specifically high risk pregnancies, i.e. those of teenaged, unwed, diabetic, hypertensive, multiple or older mothers, high risk babies, especially low birth weight and premature babies and cases of undernutrition in toddlers and children, including diagnosed cases of Kwashiorkor and vitamin A deficiency blindness. Of major concern with respect to teenagers and young adults are suicides and alcoholism, basically due to cultural maladjustment in the transition from one stage of life to the next as a result of the rapid changes in society. Chronic diseases and disorders are most common in the middle-aged and elderly, and include hypertensive cardiovascular disorders, diabetes mellitus, arthritis, chronic obstructive pulmonary diseases (COPD) and obesity. Nurses must be attuned to the promotion of wellness concepts, and strive to maintain health and prevent complications for their patients in all the phases of life.

260. Additionally, as the economy changes from an agrarian and subsistence level one to a "cash" economy, adequate salaries become of significant importance. Unfortunately for FSM nurses, their salaries remain less than those of teachers, police officers and other government workers whose job qualification is only a high school diploma. Staff Nurse I salaries range from $3,458 per annum in Yap to $4,472 in Pohnpei, with salaries in the other two states falling somewhere in between. Nurse leaders must problem-solve and politick appropriately to alleviate the frustration and discouragement staff nurses are experiencing owing to unjust compensation.

261. As the islands undergo change, so does the mobility pattern among Micronesian nurses. More nurses are moving to other Pacific islands or the United States, which provide better economical and educational advantages for

themselves and their families. Changes in immigration laws resulting from the Compact of Free Association, cultural conflicts, i.e. "old ways versus new ways", low salaries, work schedules which create hardships when both parents must work to make ends meet and/or inadequate or inappropriate management on the job are a few of the many factors which motivate nurses to leave their home island. Job dissatisfaction is most noticeable among the few nurses who received their nursing education in the United States or have earned Bachelor's of Science in Nursing (BSN) and Master's degrees. State nurse leaders must evaluate these factors, and must actively problem-solve to retain local nurses and/or entice qualified ones to return home.

262. Finally, changes in admission criteria and requirements for schools of nursing in the Pacific basin area have increased the difficulty for pre-nursing students. The use of standardized tests and/or completion of college preparatory courses in high school have delayed or discouraged students from pursuing nursing as a career. The few academically strong students almost always choose other fields than nursing, for example, medicine, computer science or business studies where the earning potential is better.

263. FSM nurses have minimal difficulty performing tasks such as starting and monitoring IV therapy, providing wound care, handling normal deliveries and carrying out physician's orders. Difficulties arise when the nurse if faced with situations in which she/he may be the head nurse of a unit when only one other member of the staff, a practical nurse (PN), may show up to work, or is faced with evaluating the job performance of a lower-level staff member who is of a higher caste status than she. The public health nurse is usually responsible for a federal programme such as the family planning, well-baby, prenatal, communicable disease or immunization programme. This nurse is expected to know the federal guidelines, write reports and plan, organize and implement activities to meet stated goals. However he/she becomes stymied when barriers develop in planned activities or when collected data indicate changes in trends or potential areas of concern. In the Pacific Basin, a recognizable trend has been for the average or lower socioeconomic students to enrol in schools of nursing. The GN has a major influence in the recruitment of students into nursing. As a role-model and counsellor/advisor, the nurse has numerous opportunities to motivate the potential nursing student and assist those needing remediation for college survival abilities and skills.

264. In January 1990, graduate and practical nurse data were collected to assess the nursing shortage and to have a more solid basis for future planning. The following summarizes the findings:

> A total of 126 GNs (53.4 per cent) and 110 PNs (46.6 per cent) were employed in the four FSM states. Practical nurses outnumbered the GNs in the hospital setting, indicating heavier reliance on lower-level staff to care for acute-care patients (chronically ill patients are normally cared for at home, according to the cultural practice, unless they become critically ill, at which time they may be hospitalized or evacuated to the United States or the Philippines). Thirty-nine public health GNs and five certified nurse midwives were available to service the FSM population of approximately 100,000.

Manpower shortage rates were high especially for GNs: Chuuk 43 per cent, Kosrae 22 per cent, Pohnpei 31 per cent and Yap 26 per cent. It was anticipated that nine June 1990 graduates from the COM School of Nursing would be available for FSM, i.e. four for Chuuk and five for Kosrae; Yap and Pohnpei had no senior students graduating in 1990. However, factors to consider in hiring new graduates included: higher salaries offered in Majuro where the school is located; cutting back of Health Services manpower in Kosrae; and dwindling funds from the Compact of Free Association.

The educational backgrounds of practising GNs indicated that 29 per cent (37) had graduated from the Trust Territory School of Nursing which existed from 1953 to 1974; 68 per cent (85) had graduated with associate degrees from the COM School of Nursing and 3 per cent (4) had earned their BSN degrees in the United States or the Philippines. Thus, 97 per cent of practising FSM graduate nurses are expected to cope with the complexities of change when they had been trained to provide quality technical bedside care.

(a) Constraints

265. While the nursing profession is the largest health profession in the nation, nursing shortages continue to be a reality. The nursing practice and shortage in Micronesia are reflective of the ongoing changes brought about by the United States trusteeship since 1944. Graduate nurses have long been used as the main source for non-nursing positions such as physio-therapists, pharmacists, nutritionists, federal programme coordinators and recruits for the 1970s Medex programme and the 1980s medical officers programme. In addition, pressures on the health-care systems and nursing practice have been aligned to meet those of the United States and to some extent, national nursing organizations such as the American Nurses Association and the National Council of State Boards of Nursing. The most critical issue for the FSM GNs today is keeping up with these rapid and complex changes.

(b) Solutions

266. In 1978, a handful of nurses from Micronesia, Guam and American Samoa, met on the campus of the University of Hawaii at Manoa (UHM) to discuss common problems and concerns for the future. Hosted by the School of Nursing, UHM, and motivated by the then Department of Health and Human Services, Region IX, nurse consultant, Dr. Marylou McAthie, the group decided to establish an organization called the American Pacific Nursing Leaders Council (APNLC). Today, APNLC remains strong and viable solely owing to the commitment of Pacific Basin nurses towards each other and to the stated purposes. Members and delegates come from the islands of American Samoa, the Commonwealth of the Northern Marianas Islands, the Federated States of Micronesia (Chuuk, Kosrae, Pohnpei, Yap), Guam, Hawaii, the Republic of the Marshall Islands and the Republic of Palau. The organization's by-laws state its purposes as being to: (i) provide a communication mechanism for nursing leaders; (ii) discuss problems confronting nurses in the American Pacific Basin; (iii) examine solutions to problems or issues facing nurses in the American Pacific Basin; (iv) explore educational needs of nurses in the American Pacific Basin; and (v) share expertise of nurses both from within and

outside the membership. The APNLC functions are to (i) convene the delegates and other interested nurses once a year; (ii) maintain a communication network for achieving the identified purpose(s); (iii) develop and implement plans and assist each jurisdiction in problem-solving regarding issues facing nurses and nursing in the American Pacific Basin.

267. The FSM national and state C.E. Coordinators are members of the APNLC Education Committee, as are other island nation coordinators. The Education Committee continues to play a major role in addressing nursing education and manpower needs on a regional level. Since the group only meets once a year at the annual APNLC (because of lack of funds), significant decision-making relative to planning, organizing and implementing strategies cannot be undertaken in a timely manner. Many of the FSM C.E. Coordinators' concerns and needs brought to the surface during the APNLC sessions have been incorporated into this proposal either as an objective or in action plans.

268. The long-term approach for FSM nurses to attain a BSN or more advanced degree is the ideal. In reality, the limited educational opportunities, high cost and lack of academic readiness portend a likelihood of academic failure or a need for long-term remediation. The concept (and value) of higher education was only introduced to Micronesians during the late 1960s when Trust Territory scholarships were first provided. In 1972, the Pacific Islanders became eligible for federal financial aid, thus enabling students to attend colleges and universities in the United States. With less than 20 years of exposure to the idea of higher education, the public school systems in Micronesia have not had the experience of time to develop stronger college preparatory programmes. Areas of weaknesses are routinely identified as English, mathematics and the sciences, all critical for success in schools of nursing. Current students with good academic potential are being encouraged to take courses in these subjects at the FSM - College of Micronesia (FSM-COM) in Pohnpei prior to seeking admission to nursing programmes on Guam, in Hawaii or elsewhere.

269. Through technical assistance provided by APNLC, the World Health Organization and one nurse expert in nursing jurisprudence, the FSM Nursing Practice Act became a reality when President Olter signed it into law as Public Law 8-45 on 23 December 1993. Prior to the passage of Public Law 8-45 (from 1979 to 1993), FSM nurses were licensed by the Medical Health Care Licensing Act of 1986, chapter 2, title 41 of the Code of the Federated States of Micronesia. The purpose of the Nursing Practice Act is "to promote, preserve and protect the public's health, safety and welfare by regulating the practice of and educational preparation and title use of the nursing profession". It is the culmination of the combined and sustained efforts of all FSM nurses spanning more than 10 years.

270. At present, the total nursing workforce makes up more than half of the entire health manpower in the FSM. As a new nation, not only has the FSM become more visible to the world community, but it also has begun attracting people from a variety of professions, nursing included. The Act does not supersede, nor will it supplant, the existing national or state public service system policies. Rather, it will complement these. It is always a sound practice to have some form of "checks and balances" in any profession, especially those dealing directly with human lives.

271. One of the provisions of the law vests power in the President to establish a national board of nursing comprising five members, within the Federated States of Micronesia National Government Department of Health Services. Four members, one member recommended by each state governor, and the fifth member recommended by the Secretary of the National Department of Health Services, were appointed by the President, and confirmed by the FSM Congress in the manner set forth in title 3, section 501 of the Code of the Federated States of Micronesia. All five members took oath of office, administered by the Vice-President, at their first meeting in October 1994. The Nursing Board will ensure that the individuals seeking nursing employment in the FSM meet minimum requirements required to provide not only quantity but, more importantly, quality nursing care.

272. In order to assist the FSM nurses to keep up and cope with the complex changes, a short-term and more practical approach is to provide on-site quality continuing education programmes coordinated by each State Continuing Education Coordinator. The current trend is to provide continuing nursing education on site by utilizing off-inland consultants, not necessarily in nursing, but frequently physician specialists in the areas of cardiology, orthopaedics, EENT, etc.

(iv) Primary health care and the mid-level health-care worker

273. With the recognition of the need to provide organized PHC in a decentralized fashion to the region, it is necessary to train the appropriate health workforce to administer PHC services. In the mid-1980s Yap state trained such a workforce and, with its decentralization programme reaching out to its far flung atolls, has developed a successful PHC system which has been recognized by the World Health Organization as a model PHC system for the region.

274. However, to make PHC a reality in the other jurisdictions, health assistant and mid-level practitioner training, retraining and continuing medical education (CME) is vital. In Pohnpei state, in the context of medical education, senior medical students from the PBMOTP, who are also licensed mid-level practitioners (Medexes), are also being trained as PHC trainers. To date they have participated in primary training and retaining programmes in Pohnpei and Yap (and soon will be training PHC workers in Kosrae state and Palau). In Pohnpei state, the health services are attempting to establish an organized and decentralized PHC system in the outer villages and outer islands. Again, in the context of medical education, PBMOTP students, have trained a new community health assistant workforce, standardized selected outer-village and outer-island dispensary operations and have implemented both long-term, on-site, outer-village and outer-island PHC supervision and distance supervision programmes from the central hospital.

275. Efforts are also being made to establish within the College of Micronesia - FSM a division of community health sciences to give the college the confidence and capacity to establish training and continuing training of a regional health workforce to meet the PHC needs of the FSM.

VII. EDUCATION, LEISURE AND CULTURAL ACTIVITIES

Article 28. Education

1. Legal context

(a) Right to education

276. The FSM Constitution, article XIII, paragraph 1 recognizes the right of people to education and mandates that the Government will take every reasonable and necessary step to provide these services.

(b) Compulsory education

277. 40 FSMC § 104 provides for compulsory education for all children, including children with disabilities, from grade 1 to grade 8, or until the age of 14.

(c) Children with disabilities

278. 40 FSMC § 232 provides for the identification, certification and education of all children with disabilities.

(d) Student loans

279. 40 FSMC, subchapters 3 and 4, provide for long-term, low interest loans for qualified students and scholarship programmes for undergraduate and graduate students.

(e) Government tuition payments

280. 40 FSMC § 371 provides for government tuition payments for students in vocational, fishing and maritime training programmes.

(f) Apprenticeship training

281. 51 FSMC § 305 creates a programme for apprenticeship training in the fields of construction, agriculture and mechanics.

2. Implementation

282. The educational system in the FSM does not include formal kindergarten, day care or preschool. Children of four to five years of age do enrol in the existing Special Education and Head Start programmes, which constitute the preschool programme in the FSM.

283. The elementary school system encompasses grades 1 to 8, while the secondary high school system is comprised of grades 9 to 12.

284. The College of Micronesia-FSM (COM-FSM) system is the post-secondary institution in the FSM. Students of college age enrol in this college in addition to colleges and universities abroad.

Preschool enrolment by state - 1992-1994

School year	1992-93	1993-94
Chuuk	N/A	1 071
Kosrae	N/A	506
Pohnpei	N/A	102
Yap	N/A	465
Total	N/A	2 144

Elementary school enrolment by state - 1992-1994

School year	1992-93	1993-94
Chuuk	14 439	14 271
Kosrae	1 693	1 698
Pohnpei	2 346	8 066
Yap	2 466	2 519
Total	20 944	26 554

Secondary school enrolment by state - 1992-1994

School year	1992/93	1993/94
Chuuk	2 581	2 968
Kosrae	671	716
Pohnpei	1 755	2 102
Yap	572	598
Total	5 579	6 384

Post-secondary school enrolment in FSM and abroad - 1992-1994

School year	1992/93	1993/94
COM-FSM	743	764
Colleges abroad	600 (estimated)	723
Total	1 343	1 487

Percentage of eligible population in school

School year	1992-1993	1993-1994
Preschool enrolment	N/A	6%
Elementary school enrolment	75%	73%
Secondary school enrolment	20%	17%
Post-secondary school enrolment	5%	4%

(a) Preschool nursery

285. The Head Start Programme is operating in all states and provides preschool programmes for a limited number of children between the ages of three and five. Head Start centres are found on the outer islands and in rural areas, as well as in the urban centres. There are only places for approximately 50 per cent of the children who are pre-registered and those that profess an interest in attending prior to the start of the school year. The programme provides not only conventional instruction in literacy and numeracy skills, but teaches simple hygiene and health messages and provides the children with two meals per day.

(b) Elementary and high school

286. The educational system served an estimated 36,087 students in 197 schools in 1994. Of these students, 32,249 attended state public primary and secondary schools. The remainder were educated in private institutions. Private schools served approximately 9 per cent of the elementary students and about 20 per cent of the high school students.

287. National law mandates universal education to grade 8 or age 14. However, with 29,700 elementary students and approximately 6,400 high school places, the opportunity for further education after grade 8 is limited to about 43 per cent of children. Pohnpei and Chuuk states no longer require an ability test for students before they can take up the limited number of high school places; Yap and Kosrae are able to accept any student who wishes to attend high school.

288. The education budget for 1990 was $23.199 million, representing approximately 18.2 per cent of the total budget. This percentage has remained relatively constant in the past five years, but with the reduction in Compact funding in 1992 and further reduction in 1997, this represents a reduction in the total amount available for education and there has been no increase to reflect the increasing number of children needing to be educated. Very few external sources of funding have been identified for education in FSM.

Number of schools, students and teachers - 1993/94

	Number of schools	Number of students	Number of teachers
Elementary			
Public	166	27 162	2 008
Private	19	2 541	230
High school			
Public	5	5 087	386
Private	7	1 297	97
Total FSM	197	36 087	2 721

Source: Human Resource Development in Micronesia, An Assessment of the Context and Conditions of Education and Training, 1994.

289. The elementary education system has 185 individual schools, 166 of which are public, the remainder private. Between them they are educating approximately 29,703 students. There are National Curriculum Minimum Standards which include English, mathematics, social studies and basic science for all grades. Social studies include specific cultural and historical course work designed by each state.

290. A new curriculum is being developed, the Teacher-Child-Parent (TCP) approach, to integrate nutrition, agriculture and health into the elementary curriculum (grades 1-8). This curriculum also offers the opportunity for parents and the community to become more involved in their children's education and school activities. In the past, parents have regarded school and the education of their children as being the responsibility of the state and the teachers. However, this new approach aims to get them to be more involved and to take more of an interest in the education of their children.

291. All FSM states offer bilingual education at the primary level, up to grade 3 or 4, after which classes are conducted primarily in English.

292. The high school education facilities consist of 12 schools, 5 public and the remainder private. The state-run schools cater for 84 per cent of the high school population. There are no figures available for the completion rate of high school students.

293. Vocational courses are integrated into the basic educational courses at the high school level (some start in grade 7): agriculture in grades 7 to 12, business in 10 to 12, home arts in grades 9 to 12, technical and industrial arts in grades 9 to 12 and power mechanics in grades 9 to 12.

294. Providing education to the dispersed insular populations in the outer islands is a costly undertaking, and often presents major problems in teacher education, qualification and certification on the smaller islands of each state, with the exception of Kosrae.

295. Although the minimum requirement for teachers is now an Associate Arts Degree, many teachers do not yet have this level of education. However, a scheme of continuing education through the College of Micronesia allows teachers to take a year off teaching to complete a one-year teacher training course, leading to an AA degree.

Number of FSM teachers and their credentials - 1993/94

	Number of teachers in training programme	Number graduated with BS/BS (1993/94)	Number with AA degree (1993/94)	Number of certified teachers	Number in staff development/ training	Total number of teachers
Public	539	14	42	432	468	2 008
Private	37	3	9	55	10	230
Total	576	17	51	487	478	2 238

Source: DOE figures for FSM Territorial Teacher Training Assistance Programme 1994.

(c) Post-secondary and vocational training

296. The College of Micronesia - FSM (COM-FSM) is the primary government supported institution for post-secondary and vocational education. The College was originally established in 1977 by the Congress of Micronesia and was supported through a 1987 treaty signed by the governments of Palau, the Marshall Islands and FSM. COM originally included the Community College of Micronesia (FSM-Pohnpei), the School of Nursing (Marshall's), the Micronesian Occupational College (Palau) and the College of Tropical Agriculture and Science and Centres for Continuing Education (in each state). The former Community College of Micronesia (now COM-FSM) came into being as a college in its own right on 1 April 1993. With the break-up of the original COM and with each jurisdiction supporting its own institution, COM-FSM is now receiving support from the FSM Congress as well as receiving some United States federal funding (Pell grants) and some funds from state scholarships. The College offers basic courses in English, mathematics, sciences, social studies, business and computing, as well as teacher training and pre-nursing courses. Continuing education centres in each state offer the teacher training courses on-site. The COM-FSM is currently in the preliminary planning stages of developing a division of community health training to meet the PHC training needs of the FSM.

297. Other vocational programmes and institutions in the FSM include the following:

The Trade Training and Testing Programme (T3), offers training in all states in the trade areas of construction, carpentry and machinery, electricity, refrigeration, house wiring, appliance repair, auto and diesel auto mechanics, power plant equipment and welding. While the T3 Programme was instituted to help offset the shortage of skilled workers in the FSM, most certified graduates move to Guam or Hawaii into the private sector.

The Pacific Basin Medical Officers Training Programme, based in Pohnpei, offers training for qualification as a medex or medical officer. Twenty-nine students from the FSM have already graduated from this programme and 17 are expected to graduate by the time the programme closes in 1996.

The Maritime and Fisheries Academy, located in Yap, provides training in maritime and fisheries technologies at high school and college levels.

298. The FSM also benefits from United Nations military-supported training programmes, United States government-supported educational in-service training and post-secondary educational scholarship programmes and grants.

299. There are other, NGO-supported, post-secondary and vocational training facilities in the FSM, although these do not provide sufficient places for the large numbers of Micronesian youths wishing to further their education or improve their job skills. For an estimated 24,249 primary students in 1992, there were approximately 2,000 students in post-secondary or vocational training or in the United States military. While these figures are not adjusted for the relative size of population in each age group, it gives an indication of the gap between the universal primary education and higher education opportunities for the youth of the FSM.

300. Problems facing the vocational training programmes include: (i) a general opinion that local institutions of higher education and vocational training are inferior to foreign institutions providing skill training opportunities; (ii) despite the number of training opportunities available in the FSM, there is a lack of counselling and information available about these opportunities for FSM citizens; (iii) lack of coordination among post-secondary institutions; (iv) lack of employment opportunities and labour market information; and (v) high student and trainee failure rates.

3. Constraints

301. The educational system faces many problems. Governments lack a clear policy definition of the status and importance of education in their development programmes, in the development of the individual citizen and in the development of their societies. Fundamentally, a higher priority for improving the quality of universal education in the FSM needs to be established and aggressively pursued by all Governments if national goals of human resource development are to be met in the next decade.

302. Specific problems include the following: no national or state government policy for student drop-outs or early leavers; no standardized or regulated policy exists governing student behaviour, tardiness, classroom behaviour, vandalism, littering, etc. No regulated or enforced (state or national) standards exist for equity in educational opportunity across states. Programmes, incentives and support to promote parent and community participation in the education processes are inadequate.

303. Current budgets cannot adequately support construction or facility maintenance, effective staff and teacher training programmes or continue to support curriculum development. The loss of certain United States Compact

funding sources in fiscal year 1992 created serious problems in maintaining existing educational standards and opportunities and this problem is unlikely to improve with further reductions in Compact funding in 1997. To date, no alternative funding sources have been identified or pursued. Schooling remains free for all students in the public schools (no fees or uniforms) although students are expected to provide items like notebooks and pencils. All the private schools charge school fees and most require students to wear uniforms.

304. All the state school systems currently lack the ability to construct new facilities or maintain and repair existing facilities. The basic institutional needs of adequate drinking water, sanitary washing facilities and toilets, sewage and waste-disposal systems are not met at many schools. Not all students have good access to schools by household proximity or public transportation.

305. Problems with regard to personnel include lack of implementation of national standards of instruction and requirements for teacher certification. Lack of standards for teacher conduct (teacher absenteeism, lack of preparation, lack of interest/poor attitude, discipline of students, lack of adequate testing-evaluation-counselling) continues to create major learning problems in many classrooms. Recruiting and maintaining qualified teachers is difficult, due in part to the lack of salary incentives and professional and community recognition. Students are not inspired to pursue a teaching career.

306. In general, the current curriculum is not meeting the educational and training needs of a major portion of the student population. Revisions and improvements are currently being developed for population studies, science and nutrition/health/agriculture (TCP). Student performance is too often below potential and below United States standards for equivalent grade levels. A recent study by Kosrae Department of Education showed that of 175 4th graders (nine years old) only 5 were reading at "a basic standard or better", indicating that there are problems with the quality of education and perhaps the difficulties of teaching using English where it is a second language. Instructional materials, teaching aids and service support for existing course work is often unavailable.

307. Much has to be accomplished if human resource development is to be accorded the importance it deserves as one of the major goals of the nation. The depressing conclusions of this section, that the educational attainment of the population of the FSM appears to be declining, have to be addressed by all government entities if the nation is to reduce its reliance on external workers, develop indigenous businesses and provide more efficient public administration.

Article 29. Aims of education

1. Legal context

(a) Decentralized educational system

308. 40 FSMC § 101 states that the policy of the Federated States of Micronesia to provide for a decentralized educational system in the Federated

States of Micronesia to participate fully in the development of the islands, as well as to become familiar with the Pacific community and the world. To this end, the purpose of education in the Federated States of Micronesia shall be to develop its citizens in order to prepare them for participation in self-government and economic and social development; to function as a unifying agent; to bring to the people a knowledge of their islands, the economy, the Government and the people who inhabit the islands, to preserve Micronesian culture and traditions; to convey essential information concerning health, safety and protection of the island environment; and to provide its citizens with the social, political, professional and vocational skills required to develop the nation.

2. Implementation

(a) Increased literacy

309. Various programmes such as General Educational Development (GED) and Literacy at Work are part of the Literacy Act for improvement of literacy throughout the United States. The two programmes mentioned above are being carried out through the adult education grant from the United States Federal Government to the FSM Government.

310. There was an increase of about 24 per cent in the number of GED graduates in 1994 (94 GED graduates) compared to 1993 (75 GED graduates). It is anticipated that in 1995 there will be more GED graduates, as it has been realized that a GED Diploma plays a significant role in wage increase, especially for those who never attended or completed high school.

311. Reading and writing in both the vernacular languages (grades 1 and 2) and English (grades 3 to 12) have been taught in all grades in all public schools in all four states of the FSM. Emphasis on reading and writing in English begins in grade 1 in most private schools.

(b) Education for all

312. Education is compulsory from grades 1 to 8. Free education is offered at the secondary level. However, in Pohnpei and Chuuk public secondary schools, the normal method for admittance to secondary schools was by entry examination. This is no longer the case as all graduating eighth graders enter secondary level without being screened. However, it is not required by statute that all graduating eighth graders attend high school. It remains a choice for individual students to make.

(c) Improved quality of education

313. Teachers play a major role in improving the quality of education in the Federated States of Micronesia. No matter how well developed the curriculum framework is, or how well the teacher training programmes are planned and organized, as long as the teachers are not well versed regarding the basic contents of the curriculum, quality curriculum and training are likely to be of little use. Teachers must be knowledgeable in all content areas.

314. The welfare of teachers needs to be considered. Commitment on the part of teachers has been deteriorating owing to lack of recognition and support for their performance in the classroom. Quality education requires commitment, and commitment requires recognition and support.

315. Plans for improving the quality of education involve developing an educational system that is home (local) based with a curriculum framework that emphasizes the teaching of skills that are useful and applicable within the home (local) environment, not one that emphasizes skills that are impractical or likely to be of no benefit. Education is also a way to preserve and maintain cultural identity.

316. Also, the planning process envisions the decentralization of educational functions to the local communities. This will allow the communities in the FSM to make decisions about their educational programmes, and to develop a sense of ownership of their school systems.

Article 31. Leisure, recreation and cultural activities

317. The major emphasis in youth programming has been on developing sports facilities and on organizing youth in league sports. Activities have yet to be developed for youth with no interest in sports. The recent increase in expenditure on sports facilities and the emphasis on promoting sports is justified as a means of reducing juvenile crime by providing activities to occupy young people in their free time. In many instances organized sports have helped alleviate youth tensions, although they do not address the basic employment needs of youth, nor have they reduced teen pregnancy rates.

318. State youth has played a lead role in operating summer youth work programmes and some offices provide counselling services, as well as general education on subjects such as family planning, HIV/AIDS and parenting skills.

319. Several community-based organizations have been developed to provide structured activities for the large youth population: scouting organizations, church groups, youth clubs and 4-H programmes all provide supervised after-school and weekend activities in which children learn a variety of skills and perform services deemed valuable by society. Unfortunately, not all of these have been adapted to the Micronesian context and thus participation is not as widespread as it might otherwise be.

320. Even though organized programmes tend to protect our youth, the majority of these activities still lack structure, adult volunteer supervisors, funding and facilities. Unless these issues are addressed, more and more young people will find themselves susceptible to the more troublesome elements within our community and at risk for juvenile delinquency.

VIII. SPECIAL PROTECTION

Article 22. Child refugees

321. The problem of refugee children does not exist in the FSM. In the event that children were to seek refuge in the FSM, the Government, with the

assistance of international agencies, would seek to reunite the child with the parents. The FSM Constitution provides for equal protection of all people, regardless of race, ancestry or national origin.

Article 30. Children of minorities

1. Legal context

(a) Equal protection

322. The FSM Constitution, article IV, paragraph 4, provides that equal protection of the laws may not be denied or impaired on account of sex, race, ancestry, national origin, language or social status.

2. Implementation

323. With the exception of the people of Nukuoro and Kapingamarangi (islands of Pohnpei state) who are culturally and linguistically Polynesians, the inhabitants of the Federated States of Micronesia are Micronesians. Because the four states are separated by large expanses of water resulting in isolation and infrequent interaction, unique traditions, customs and languages developed on each of the islands prior to Western contact. Despite these many differences, or perhaps because of them, all groups are encouraged to practise their own culture, religion and language.

Article 32. Child labour

1. Legal context

324. Currently, there are no laws in the FSM which address the issue of child labour.

2. Implementation

325. In the FSM, the issue of child labour has not been a known problem. Child labour of an exploitative nature does not exist in the FSM. What does exist is that children are expected to perform daily chores around the home. These chores include cleaning in and around the house, working in the gardens, fishing, child care for younger relatives and other day-to-day domestic activities. Some children are also expected to help with the operations of small family owned businesses if their families have one.

326. The positive aspect of this type of child labour is that the children of the FSM quickly master local skills at an early age. This leads to increased self-esteem and confidence among the youth of the FSM. The negative aspects of this type of child labour is that the chores assigned may deprive the children of valuable time in which they may play with other children. In some remote communities, the tasks assigned to children may go beyond the capacity of the children and may be interpreted as punishment by the parent(s).

327. The type of child labour that exists in the FSM is gradually being seen as a problem. The extent of the problem is unknown at this time, however. The problem is not that the children are being exploited as a labour source by

businesses, rather that the activities performed by the children sometimes interfere with the child's ability to attend school or participate in other youth activities.

3. Constraints

328. Since there are no laws in the FSM that deal with child labour it is currently impossible for the Government to protect children in the FSM from being exploited as a labour source. It is, however, a crime to prevent a child under the age of 15 from attending school.

329. The types of child labour discussed above are culturally ingrained in the FSM. Formal schooling is not yet seen as a priority by many FSM parents and preventing a child from attending school may not be seen as a deprivation of the right of a child to education.

330. Furthermore, the issue of child labour in the FSM needs to be defined so that it can be addressed in the proper manner.

4. Solutions

331. The definition of the problem of child labour in the FSM needs to be addressed first. Since the FSM includes four different states with different culture groups, it will be necessary to examine the extent of the problem of child labour in each of the four states. The FSM can also look for some guidance in this area to other Pacific island nations to see first how other nations have elected to deal with this issue. From there, legislation should be developed and proposed to the Congress of the FSM to protect the children of the FSM from child labour which interferes with their development.

332. The general public will also need to be educated about any legislation passed by the FSM Congress in this area. Legislation in the area of child labour without public education on the issue would be fruitless. Furthermore, enforcement of any legislation will need to be sensitive to the cultures of the FSM, but must exist to protect the children of the FSM.

Article 33. Children and controlled substances

1. Legal context

(a) Controlled substances

333. 11 FSMC, Controlled Substances, classifies controlled substances, provides for regulation of their manufacture, distribution and dispensing and also establishes criminal offences and penalties for trafficking and possession. 11 FSMC § 1147 makes it a separate crime, with severe penalties, to distribute drugs to children under the age of 18.

2. Implementation

334. The Substance Abuse Programme receives United States federal funding which pays for most of the staff salaries and operating costs. It receives a

small amount of Compact funding which is shared with the Mental Health Programme. The Substance Abuse Programme is run in conjunction with the Mental Health Programme.

335. The programme focuses primarily on pregnant substance abusing women, alcohol and drug abusing adolescents, drug exposed infants and infectious diseases in substance abusers. The main substance abuse problems in the youth of FSM are alcohol, marijuana, betel nut and under-age smoking of cigarettes. As yet there are few recorded instances of "hard" drugs and intravenous drug use in FSM, although it has the potential to become a problem as travel to and from the FSM increases.

336. Recognizing the potential problem, the FSM is currently exploring means to increase the ability of local staff to provide substance abuse education and consultation, thereby increasing public awareness of substance abuse problems at all levels.

3. Constraints

337. As yet there is minimal legislation to protect youth from certain of these substances (for example, no minimum age for purchase of tobacco) and where legislation exists, enforcement is almost non-existent. While legislation alone will not prevent the problem, stricter controls may aid the fight against substance abuse.

Article 34. Sexual exploitation/abuse

1. Legal context

(a) Sexual assault

338. 11 FSMC § 913 makes aggravated sexual assault a crime.

(b) Sexual abuse

339. Draft legislation has been prepared that would define and criminalize sexual abuse, sexual exploitation of children, selling or buying of children and certain activities relating to materials involving the sexual exploitation of minors.

2. Implementation

340. The Child Abuse and Neglect Programme (CAN) was set up in 1991 with United States federal funding. However, this funding terminated in October 1993 and the FSM Congress took over full responsibility for the CAN programme as of October 1994. This makes the FSM the first of the former United States jurisdictions to support its own CAN programme.

341. Care has been taken to develop culturally sensitive delivery of services, specific to each state, in order for each state programme to keep pace with the different rates of sociocultural development. As in Western countries, child abuse and neglect is considered a very sensitive issue, and as such the

programme has moved slowly to gain social acceptance before being able to intervene more actively in many cases. To date, Kosrae is the only state to have passed a child abuse and neglect law.

342. Although data is now being collected on the incidence of child abuse and neglect, there is almost certainly significant under-reporting. The numbers reported probably have more to do with cultural values and restraints than actual distribution or incidence of the problems (more cases which are of a less culturally sensitive nature are reported). At present it appears that many of the interventions are for educational and medical neglect (children being kept away from school or infants that have not been taken to medical facilities), rather than physical neglect or sexual abuse.

343. In one of the few available studies in 1986, is the Micronesian Seminar coordinated-10-month study of child abuse and neglect in Micronesia. Of the 1,027 cases studied, 704 (69 per cent) were incidents of neglect. There were 194 cases of physical abuse (20 per cent) and 115 cases of sexual abuse (11 per cent). The percentage of males and females among those who were abused is about the same. Cases of neglect were highest in Pohnpei, and cases of physical and sexual abuse were highest in Yap.

344. The focus of the programme has become educational, rather than clinical or investigatory. Presentations regarding sexual abuse are being made at community meetings, church groups and social gatherings. Radio programmes have been prepared in the vernacular for each state. Liaisons have been set up between other government agencies, religious groups, youth officer and traditional leaders. By creating this public awareness, it is hoped the problem will be addressed at the community level.

3. Constraints

345. Presently, there is a lack of both funding and legislation to support child abuse and neglect programme activities. This has led to a lack of adequately trained personnel as well as a failure to make available general knowledge of abuse services. In the FSM there is also some cultural and social unwillingness to acknowledge the existence of abuse and accept the consequences of reporting such abuse.

Article 35. Trafficking in children

1. Legal context

(a) Kidnapping

346. 11 FSMC § 918 makes the removal or confinement of a person by force, threat or deception, as in the case of a person under the age of 14 and without the consent of their parents, a crime.

2. Implementation

347. Although the FSM recognizes that the kidnapping and trafficking of children is a serious problem in some areas of the world, there have been no reported cases of child victims of such crimes in this country.

Article 37. Children in conflict with the law; Article 40. Children and justice

1. Legal context

348. The FSM Constitution provides the foundational requirements for children in conflict with the law.

(a) Declaration of rights

Article IV of the FSM Constitution, entitled Declaration of Rights, provides the following:

> "A person may not be deprived of life, liberty or property without due process of the law. Persons are to be secure in their persons, houses, papers and other possessions against unreasonable search, seizure or invasion of privacy. All defendants in criminal cases have a right to a speedy public trial, to be informed of the nature of the accusation and to have legal counsel. No person may be compelled to give evidence against themselves or be tried more than once for the same offence. Excessive fines or cruel and unusual punishments may not be imposed or inflicted. Capital punishment is abolished."

(b) Juveniles

349. 12 FSMC, chapter 11, Juveniles, provides that flexible procedures shall be used involving criminal offenders under the age of 18. These flexible procedures include detention, if necessary, apart from adult offenders; informed hearing in closed session and release into the custody of parents or guardians.

(c) Prosecution of minors

350. 12 FSMC § 1101 allows for the prosecution of an accused offender 16 years of age and older if in the opinion of the court the physical and mental maturity so justifies.

2. Implementation

351. The juvenile justice system in the FSM recognizes and encourages the exhaustion of parental interventions and supervision before resorting to judicial proceedings. State police departments have developed programmes to give juveniles the opportunity to "rehabilitate" themselves, without judicial intervention. Two government-sponsored programmes, Second Chance and Youth RAP, provide juveniles another chance and counsels parents and juveniles in the hope of ameliorating family problems.

352. All states have separate facilities for juvenile detention, although they are seldom needed. If juveniles are detained, they are allowed liberal visitation with their family and the use of a telephone. Records are kept of all juvenile proceedings, but such information is confidential.

Articles 38 and 39. Children in armed conflict

353. The FSM has no armed forces nor has it been involved in any recent hostilities. Consequently, no children are recruited, take part in or are affected by armed conflict. Under the Compact of Free Association, FSM citizens 18 years or older may enlist in the United States armed services.

IX. CONCLUSION

354. The Convention on the Rights of the Child represents the most significant commitment to children's rights ever made. The accession by the Federated States of Micronesia to the Convention, together with national policies adopted by the FSM, demonstrate this country's desire to honour that commitment.

355. Many countries that have ratified or acceded to the Convention, particularly developing countries, have found themselves in the unenviable position of needing to create law and other mechanisms, both formal and informal, to begin implementation of the Convention. Often this simply involves the codification of traditional moral norms into statutes, regulations and/or formal government structures.

356. The FSM, as a developing country, is in many respects fortunate to have inherited, as a legacy of its Trust Territory days, numerous statutes and policies which protect the rights of children and thereby mirror many of the provisions contained in the Convention. In many other respects, however, the position of the FSM is far less enviable than that of those developing nations forced newly to confront and articulate their commitment to children.

357. Having been supplied the words, the FSM has struggled to lend meaning to these words with actions. At best, legislation represents a sincere attempt by government to address issues of children's rights and is followed by a corresponding allocation of resources. At worst, legislation is nothing more than lip service to a goal never intended to be attained.

358. The attempt by the FSM to improve the quality of its children's lives is sincere and achievements measurable. Sometimes in the anxiety of slow economic development, high out-migration levels, elimination of most United States federal programmes and the potential end of funding under the Compact of Free Association, the country has temporarily placed a lower priority on its most valuable resource its children. These difficult economic times, however, have also forced the FSM to identify, mobilize and use available resources more judiciously.

359. The FSM has also come to understand that the resources available to achieve children's well-being cannot, and should not, be limited to economic resources. The FSM possesses a wealth of human resources who have the knowledge, skill, motivation, energy and commitment to secure children's rights. There are organizational resources available in extended family support, health, education, juvenile justice and international monitoring systems. The nation recognizes it must play a critical role in catalysing and

mobilizing the broad array of both traditional and non-traditional players in society, whose efforts are essential for the continued and effective implementation of the Convention on the Rights of the Child.

360. In fulfilling our obligations to our children, planning for the progressive achievement of goals over time has begun. Primary health care and basic health services are being reinforced. Communicable diseases are being prevented and controlled more efficiently. Clean water has become more widely available and environmental sanitation is being improved. Malnutrition is being reduced and major efforts are under way to eradicate nutritional deficiency diseases. Compulsory education has been universalized and equitable access to schools achieved. Teachers are being trained and curriculums made more relevant. Child labour legislation need to be enacted and should be linked to measures to improve access to educational opportunities.

361. In the future, the effectiveness of activities to implement the Convention will have to be increased and they will have to be better organized. The Government needs to consider the impact on children when implementing new policies and legislation. Most importantly, educational and promotional work must be intensified at the community level to continue to improve the lives of our children and improve implementation of the Convention.

References

FSM Draft Plan of Action for Food and Nutrition - 1995

FSM Draft Situation Analysis for Children, 1992-1995

FSM National Nutrition Survey - 1987-1988

FSM Second National Development Plan, 1992-1996

Human Resources Development in Micronesia - Asian Development Bank - May 1995

Pacific Health Dialog, 1194; 1 (2): 6-12

WHO New Horizons in Health. Revised June 1995

WHO Yanuca Island Declaration. WHO/HRH/95.4. March 1995